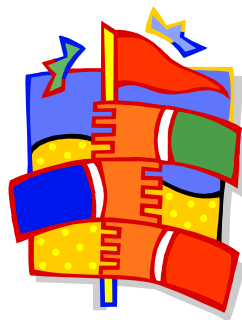


# *Geriatric*



*Contributors:*  
*Julie Jensen, PhD*

*Washington Institute for Mental Illness Research & Training -  
Eastern and Western Branch*

*Jeanette Semke, M.SW, PhD*  
*University of Washington*

# *A Review Of The Literature*

## **OLDER ADULTS<sup>4</sup> IN WASHINGTON STATE**

Washington State ranks 7<sup>th</sup> in the United States in the proportion of its population that is 65+. Also, it has one of the fastest growing populations of older persons in the country with the number of persons 65 years of age and older projected to double by 2025 (US Bureau of the Census, 2000). Between 1995 and 2010, the annual rate of increase can be expected to be between 5.1 to 6.9 percent (US Bureau of the Census). In 2002, older adults accounted for 15 percent of the total population in Washington State. By 2025, the proportion of older adults in the state is estimated to be 20.2 percent (US Bureau of the Census).

As the population ages with the baby boomers, there will be greater attention given to the most common mental disorders of late life, including dementia, depression, anxiety, and substance abuse disorders. While the majority of older adults enjoy healthy and productive lives well into their golden years, about 20 percent of older adults experience symptoms of mental illness that are serious enough to warrant treatment (DSSH, 1999).

## **THE PREVALENCE<sup>5</sup> OF MENTAL ILLNESS AMONG OLDER ADULTS**

Prevalence estimates of mental disorders among older adults vary widely, depending on the definition and procedures used for counting a case (e.g. clinical diagnostic approaches versus screening approaches), differences in setting (community versus inpatient versus health clinic, etc.), and sampling procedures (Gallo & Lobowitz, 1999; Bartels, et al., 2002). In addition, older adults with mental illness often present with a different pattern of symptoms than younger adults which makes detection, diagnosis, and measurement more difficult (DHHS, 1999). Older adults also experience a number of age-related illness conditions (e.g. arthritis, osteoporosis, heart disease, urinary tract infection, high blood pressure) that co-occur with mental illness that further complicates making an accurate diagnosis of mental illness. Indeed, mental disorders of late life often go undetected, undiagnosed, untreated, or mistreated (DHHS, 1999, 2001a).

### *Depression*

Estimates of major depression in community samples of older adults range from .8 to 20 percent (DHHS, 1999). About 15 percent of older adults have been estimated to have significant depressive symptoms that do not meet criteria for a major depression although warrant treatment. Rates of depression increase when special populations of older adults are examined, e.g. nursing home residents (75 percent) and primary care patients, (37 percent).

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<sup>4</sup> In this report, we use the term “older adult” to refer to individuals 60 years of age and older in the population which is consistent with Washington State’s cutoff for this age group. However, 55+, 60+, and 65+, are commonly used throughout the literature and will be duly noted when appropriate.

<sup>5</sup> Prevalence refers to the proportion of the population that meets criteria for a disorder within a specified time (Gallo & Lebowitz, 1999).

Depression often co-occurs with substance abuse (DHHS, 1998) and has been found to have a strong link to suicide among older adults (DHHS, 1999; 2001a, 2002).

Indeed, older adults have the highest rates of suicide compared to any other age group. According to the National Strategy for Suicide Prevention (DHHS, 2001b), on average, there is one suicide among persons aged 65 and older every 90 minutes. Moreover, older adults comprise 13% of the population and yet represent 19 percent of all suicide deaths. Older Caucasian men have the highest rates of completed suicide of all individuals 65 years of age and older; 84 percent (DHHS, 2001b). Even though older adults are less likely to attempt suicide, they are more likely to succeed with suicide than any other age group. They use more lethal methods than younger age groups including, firearms (71%), overdose (11%) and suffocation (11%) (DHHS, 2001b).

A number of factors have been found to increase an older person's risk of suicide: depression, alcohol abuse, social isolation, serious health problems, and loss of a spouse through separation or divorce (DHHS, 2001b). A significant number of older adults have recently visited a physician prior to suicide (DHHS, 2001b).

### *Anxiety Disorders*

Anxiety disorders are reported to be the most prevalent mental disorders among older adults (DHHS, 1999). However, they are the least studied and treated of the mental disorders of late life. Community-based studies estimate that between five (Gallo & Lebowitz, 2002) and 11.4 percent of older adults meet criteria for an anxiety disorder (DHHS, 1999). Panic disorder and obsessive-compulsive disorders have been reported as low as .5 percent among older adults, whereas a generalized anxiety disorder has been estimated to range from 1.1 percent to 17.3 percent in community samples (DHHS, 1999). Symptoms of anxiety, e.g. worry, nervous tension, have been found in 17 percent of older men and 21 percent of older women (DHHS, 1999).

### *Alzheimer's Disease and other Dementia's*

Prevalence rates of Alzheimer's disease and other dementia's vary widely. There is evidence that suggests that about half of individuals over the age of 85 have some form of dementia (Gallo & Lebowitz, 1999). Alzheimer's disease, the most prevalent form of dementia, afflicts 8 to 15 percent of individuals over the age of 65 (DHHS, 1999). Hebert et al. (2003), measured the current incidence of Alzheimer's disease among individuals free of the disease at baseline that were residing in three adjacent Chicago neighborhoods to estimate prevalence rates in the US population. Using the 2000 census, they estimate that in 2000, 4.5 million persons were afflicted with Alzheimer's disease in the US population. They go on to predict that by the year 2050, the number will increase to 13.2 million; an approximate 3-fold increase.

Older adults can be successfully treated for mental illness in their later years. A number of recent federal reports (DHHS, 1999, 2001a, 2002) provide a comprehensive review of the efficacy of different types of treatment interventions used with older adults (e.g. pharmacological, psychosocial, electroconvulsive therapy) and will not be presented in this document.

## **THE NEED FOR SPECIALIZED MENTAL HEALTH SERVICES FOR OLDER ADULTS**

*The large unmet need for treatment of mental disorders reflects patient barriers ... provider barriers... and mental health delivery system barriers (DHHS, 1999, p. 341).*

Some older adults experience mental illness for the first time in their later years, yet, relatively few seek help from mental health professionals (DHHS, 1999, Gallo & Lebowitz, 1999). Using prevalence estimates from the Baltimore ECA study, Rabins (1996) concludes that up to 62 percent of older adults have an unmet need for mental health services. Moreover, he suggests that this unmet need increases with advancing age; with the oldest-old exhibiting the greatest unmet need. Best estimates indicate that older adults underutilize mental health treatment more than any other age group (Lebowitz et al., 1997). Persky (1998) reports that older adults make up only 7 percent of all inpatient services, 6 percent of community-based services, and 9 percent of private psychiatric care.

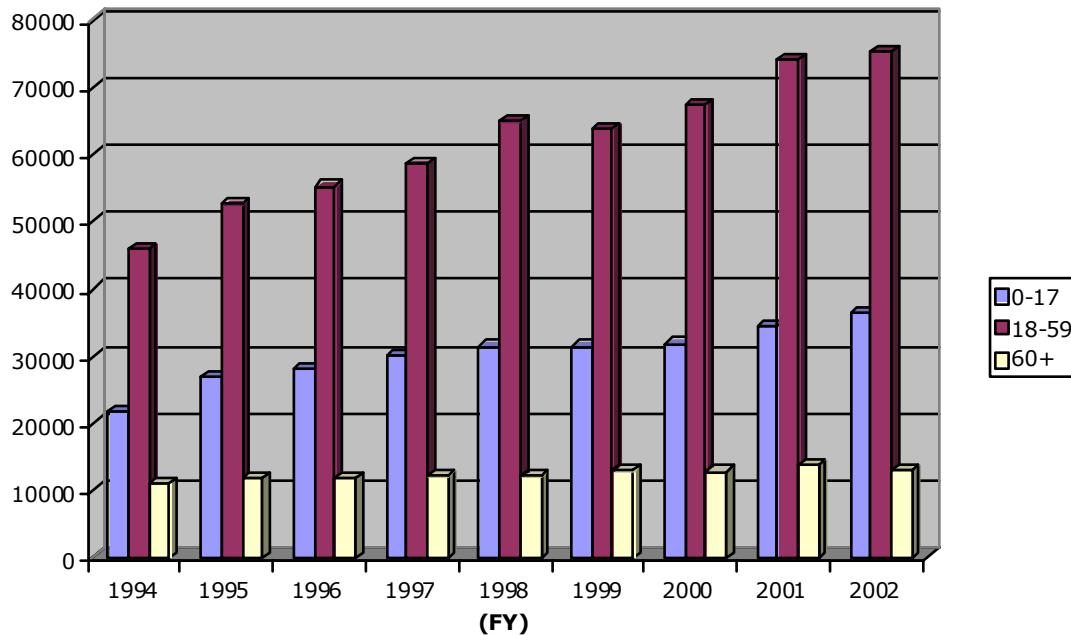
The mental health needs of racial and ethnically diverse older adults are relatively unknown. The President's New Freedom Commission on Mental Health (2003) acknowledges that access, quality and outcomes in mental health care are disproportionately low for members of racial and ethnical minority groups. Culturally competent and appropriate treatments, strategies and models are seriously lacking, especially for older adults (DHHS, 2001a).

There has been a recent effort to develop an evidence base for mental health services for ethnic minority elders through two "Targeted Capacity Expansion" grant programs funded by the Center for Mental Health Services, SAMHSA: "Meeting the Mental Health Needs of Older Adults" and "Reducing Racial and Ethnic Disparities in Mental Health." Together, these grant programs are supporting the development, evaluation and dissemination of six mental health programs focusing on diverse racial and ethnic populations (e.g. Hispanics, Hmong, Mexican-Americans, Latinos, American Indians, and African Americans).

The magnitude of need for mental health services by older adults is difficult to determine. Over the past ten years, DSHS Mental Health Division has made several attempts to estimate the number of persons, by subgroup, which are in need of mental health services. Several methods or formulas have been used including, prevalence estimates from the Epidemiological Catchment Area Studies, parity with percentage of representation in the population, 95% parity targets ranging from minimum to exemplary, and penetration rates. However, there has been considerable debate over the years concerning what accounts for a fair and equitable formula for estimating need and the resultant number of individuals to be served by the public mental health system.

No matter how need is defined, the number of older adults served from 1994-2002 has stayed about the same despite their steady growth in the population (See below). The number of children and adults (18-59) show steady increases in numbers served during this same time period.

## MHD: Total Numbers of Consumers Served 1994-2002



Source. DSHS Mental Health Division, 2003.

### CHALLENGES IN PROVIDING MENTAL HEALTH SERVICES TO OLDER ADULTS WITH MENTAL ILLNESS

There are many reasons that older adults with mental illness are under-served and consequently, left untreated. The very nature of the conditions some older adult's experience--memory loss, depression, anxiety and paranoia--can render them incapable of seeking help from mental health and other social service systems. Older adults who need mental health services may simply not know how to access services. Some may seek help from their primary care physicians, many of whom have not been adequately trained in how to recognize and treat mental illness in this population (Bartels, et al., 2002). Many have difficulty navigating service delivery systems that are fragmented and funding mechanisms that are complicated and inadequate (Gatz, 1995). This is especially problematic because illness conditions and care needs of the majority of older adults cross many different systems of care and provider networks.

**Individual Factors.** There is a negative stigma associated with mental illness among older adults. Many grew up during the Depression era when people with mental illness were sent away to "insane asylums" never to be seen again. There was a sense that one should "pick yourself up by the boot strap and carry on" no matter what was wrong or difficult. Mental illness was not discussed openly and was a great source of shame and personal failure. Still today, many older adults find it difficult and painful to discuss their inner most feelings and symptoms of mental illness.

Moreover, many older adults have strong feelings of pride, stoicism, self-reliance and independence and are reluctant to ask for or accept “charity” or help from others. Older adults may fear that by accepting help, they will lose control over their lives. If someone discovered how poorly they functioned then they might be taken out of their home and placed in a nursing home. In addition, some older adults lack family or a supportive network to access help for them (Pearlin & Skaff, 1995).

**Service System Factors.** The current mental health system is a complex array of public and private systems of financing and service delivery. The President’s New Freedom Commission on Mental Health (2003) concludes that “the mental health system is fragmented and in disarray leading to unnecessary and costly disability...including lack of care for older adults with mental illness” (p. 3). There has been little increase in Federal and State funding for mental health services over the past few years. In fact, mental health services have traditionally been under-funded compared to general health care services (DHHS, 2001a).

Medicaid and Medicare are the principal sources of funding for mental health services yet favor more costly inpatient care over community-based care, acute care versus chronic or preventive care, and time restricted services over the comprehensive care that is needed (Bartels et al., 2002). Older adults are at an added disadvantage because many are not eligible for Medicaid and/or refuse to accept government assistance. Furthermore, Medicare mental health coverage is very limited and covers few community-based mental health services. Within the publicly-funded mental health system, “specialized geriatric programs and clinical case management for older people are inadequate or poorly implemented” (DHHS, 1999, p. 376).

These limitations are typical of state mental health service systems. Washington State’s system is no exception. Like many states, Washington State has adopted managed behavioral healthcare. Service providers are challenged with how to serve older adults in this state’s capitated managed care environment. Within a capitated budget, the Washington State Mental Health Division specifies which populations are to be a priority for service; however, regional mental health authorities can further refine these definitions to meet their local needs and budgets. Competition for scarce resources is strong and priority populations are the first to receive services with available funding. Because older adults often suffer in silence, especially with late-life mental illnesses, they rarely become a priority for services until a crisis event or hospitalization brings results (Bartels, et al., 2002).

Another service system barrier is the fact that there is a general lack of consensus among mental health, health, aging, and other social service providers concerning *who is responsible for serving whom and under what circumstances*. This is especially true for persons with Alzheimer’s disease and other dementias. Indeed, the systems of care designed to meet the needs of older adults are not well coordinated and integrated (Bartels et al., 2002). There is little coordination of care between the public mental health system and primary care even though older adults are more likely to seek help from the latter. Because most primary care physicians or health care providers lack training in geriatric mental health, mental illness often goes undetected and untreated.

**Trained Workforce.** There is a consensus among geriatric mental health providers that our workforce is ill prepared to provide both the current and future mental health care needs of our older adult population. According to a recent consensus paper by leading authorities in geriatric mental health, “a national crisis in geriatric mental health is emerging (Jeste et al., 1999, p. 848). There is a national shortage of mental health, medical and social service providers who have training and expertise in geriatric mental health care (Abramson & Halpain, 2002; Knight, Teri, Wohlford & Santos, 1995; Bartels et al., 2002, The Presidents New Freedom Commission on Mental Health, 2003).

Halpain and colleagues (1999) examined various sources to provide estimates of our nation’s need for professionals that are trained in geriatric mental health. Years for projections ranged from 2000 to 2020. Estimates projected the need for:

- 595,000 RN’s, 250,000 LPN’s, 500,000+ nurses aides and 19,000 specialized gerontological nurses and practitioners by 2000;
- by 2010, 400-500 academic geriatric psychiatrists, in addition to 4,000-5,000 that are active in clinical care; 1,221 physician faculty and 919 non-physician faculty to provide training to medical students; 50,000 to 60,000 full-time social workers; and
- 5,000 full-time doctoral-level clinicians and counseling geropsychologists by 2020.

The importance of this issue is also recognized in service systems beyond mental health. For example, the National Policy Summit on Elder Abuse in 2001 included geriatric mental health services as one of the top ten issues for its Action Agenda:

Age-appropriate specialized mental health services need to be available and accessible to include aggressive outreach, intensive case management and specialized clinicians to provide acute and ongoing services for victims; dementia-related accurate diagnosis and treatment, capacity assessment and surrogate decision-making; age appropriate substance abuse, medication management and education, and mental health and substance abuse treatment for perpetrators (The National Center on Elder Abuse, 2001).

Also, there is recognition in Washington State government that the need for geriatric mental health specialist training transcends the specialty mental health service arena. DSHS Aging and Disabilities Services Administration has identified the need for specialized geriatric and mental health training for their licensed providers of boarding homes and adult family homes. Operators and managers of facilities that serve persons with mental illness and/or dementia must complete a twenty-hour long training and pass a competency test in order to care for someone with mental illness.

Thus, Washington State is no exception in its need to train a workforce prepared to provide specialized geriatric mental health services. Until recently, the Washington State DSHS Mental Health Division supported the *Geriatric Mental Health Specialist* training certificate program. While no systematic evaluation of the training program was ever carried out, the training increased the capacity of Washington State’s mental health workforce to work successfully with older adults with mental illness. Many of these graduates have gone on to

be supervisors of Specialty Older Adult Mental Health Programs within our public mental health system. The last Geriatric Mental Health Training Certificate program was held in 2000 and trained 40 individuals. Professionals in the field of gerontology have noted the absence and point to the growing need for ongoing and comprehensive training.

**Advocacy.** There is also a paucity of advocacy groups that support geriatric mental health. The National Alliance for the Mentally Ill and their state and local chapters have made great strides in bringing the major issues facing adults with mental illness to the forefront. The American Association of Retired Persons, perhaps the largest senior advocacy group, has primarily focused on the health and economic well-being of older American's. Older adults with mental illness have not been a primary focus of attention due to the many barriers discussed earlier.

A national non-profit advocacy group that recognizes the challenges described above was formed in 1998 and promises to impact national mental health policy. It is called the Older Adult Consumer Mental Health Alliance (OACMHA). This national consumer-based advocacy group focused on the needs of older persons with mental disorders and their families. Its purpose is to improve the quality of life of older persons affected by mental illness, and their family caregivers, by promoting through advocacy and public education, the development of accessible, affordable and age-appropriate mental health services (<http://www.oacmha.com/>). Targeted for membership are older consumers of public and private mental health services and their family caregivers.

To date, OACMHA has had an impact on raising awareness of the mental health needs of older adults on a national level. Members urged The President's New Freedom Commission on Mental Health to address the mental health issues of older adults separately from the general adult population. Members have also been active in advocating for Representative Patrick Kennedy's "Positive Aging Act." This legislation would improve the accessibility and quality of mental health services for older adults through new authorities and resources within the Substance Abuse and Mental Health Services Administration, DHHS. OACMHA is also working with the National Alliance for the Mentally Ill, the largest advocacy group for persons with mental illness, to increase awareness of mental health issues facing older Americans. It should be no surprise that our own John D. Piacitelli, former Program Manager for Elderly Services, Mental Health Division, DSHS, has been at the helm of this consumer movement. At 73 years of age, Mr. Piacitelli's fight to improve mental health services for older adults continues.

## **MODELS OF GERIATRIC MENTAL HEALTH PRACTICE**

What follows is a discussion of issues that arise when determining best and promising practices. A first step in developing a guide for best and promising practices in geriatric mental health is to define "what is an evidence-based, best or promising practice". Two main tasks involved in arriving at a definition are: 1) to determine what is meant by "geriatric mental health practice" and 2) to establish a set of criteria for what constitutes "evidence" and what constitutes "best" and "promising".



**Defining geriatric mental health practice.** In addressing the first task, we chose to focus on practice models rather than treatments applied at the individual level. The decision to limit the scope of our review was made for purposes of time and space. How we came to the decision to focus on programs rather than individual treatments is described below.

Secondly, given the current knowledge base for mental health services, we argue that development and implementation of effective geriatric mental health practice models will have the widest impact on the mental health of older adults<sup>6</sup> in Washington State. The most pressing need among mental health services planners is for more information about effective program models.

- **Individual treatments are intertwined with the organization of programs.** In order to clarify what constitutes a mental health strategy or program, we turned to the recent literature on evidence-based mental health services. In its *National Plan of Research to Improve Services for Individuals with Severe Mental Illness*, the National Institute of Mental Health distinguishes two major types of mental health services research: 1) clinical services research in which effectiveness and cost are measured with the individual as the unit of analysis and 2) service systems research in which organization and financing of the service system are the foci. Goldman et al. (2000) state,

*“Theoretically, the mental health service system organizes effective treatments into service arrangements of known effectiveness and efficiency. Having completed the assessments of treatments applied at the individual patient or client level (clinical services research), investigators would proceed to establish the effectiveness of various organizational strategies (services system research).”*

Although that approach sounds sensible, it did not fit with our experience as we reviewed mental health practices. The challenge that we encountered in our review of the literature is that in many cases, it is not possible to clearly distinguish the treatment intervention from the organizational strategy. Goldman et al. (2000) acknowledge this when they state,

*“The ‘treatment’ is embedded in an organization or identified with a particular organizational arrangement, such as in case management, assertive community treatment or residential treatment. For these service interventions, the clinical services research literature serves as an important source of guidance, along with the service systems research literature.” (p. 70)*

We concluded that programs and organization arrangements were closely connected to the individual level interventions and key to their successful implementation.

- **An array of program models is important to geriatric mental health.** We recognized that there is a wide range of organizational and service system structures—many of which transcend specialty mental health—that are potentially effective in improving the mental health of older adults. This array of geriatric mental health program models reflect the many different locations that older adults might access mental health services.

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<sup>6</sup> We acknowledge that effective individual clinical interventions are very important. Certainly a well-organized program will be of no benefit to consumers if effective clinical practices are not used.

Locating services “where older adults are comfortable” –in their homes, in primary care clinics, in senior centers, long-term care residences, at adult day centers—is key in many of these models.

In addition, multiple services systems are often included in efforts to take a holistic approach to meeting the health and mental health needs of older persons. For example, these efforts have resulted in a range of models that are designed to integrate physical and mental health services. Service integration is important for this population due to the high prevalence of co-occurring physical illnesses and complexities introduced by physiological changes associated with aging. Therefore, organizations and social and health service settings outside the specialty mental health system often become the places where older adults have their mental health needs met.

Certainly, a public mental health system has a specific role in many of these geriatric mental health practice models. However, distinctions between mental health care, physical care, and social care become blurred as models become more comprehensive and community-based. Thus, the field from which best and promising geriatric mental health practice models are identified is indeterminate, broad, and evolving. This context makes the task of selecting best and promising mental health practice models for older adults more challenging than it would be if the pool of programs were limited to specialty mental health programs.

**Existing literature on individual treatments.** There is already an available literature on treatments applied at the individual level. The effectiveness of these individual treatments is often intertwined with how programs are organized in the real world of mental health services. We refer the reader to the following recent reports and resources:

Chapter Five of the Mental Health, A Report of the Surgeon General at <http://www.surgeongeneral.gov/Library/MentalHealth/home.html>;

Administration on Aging’s companion report to the Surgeon General’s report is entitled, Older Adults and Mental Health: Issues and Opportunities (2001);

Bartels, et al., (2002). Evidence-based practices in geriatric mental health care;

Two journal issues with special sections on geriatric mental health:

Psychiatric Services, (1999), Volume 50 (No. 9), pp. 1157-1208.

Psychiatric Services, (2002), Volume 53 (No. 11), pp. 1389-1431.

Useful web sites (See Appendix 1).

**Establishing criteria for best and promising program models.** In addressing the second task, we reviewed different methodologies for establishing a designation of “evidence-based”, “best”, and “promising” practices. We then reviewed geriatric mental health program models and how they matched with selection criteria.

**Criteria currently used to evaluate program models.** A significant amount of work has been done at the national level to establish criteria for what constitutes “evidence” for evidence-based practices. The Center for Substance Abuse Prevention (CSAP, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration) has created a National Registry of Effective Programs that include effective

substance abuse and mental health programs (NREP, <http://modelprograms.samhsa.gov>). *The SAMHSA Model Programs* included in the registry have undergone a rigorous multi-step evaluation process to determine the degree of “evidence” available to classify programs in one of three categories: Promising programs, effective programs, and model programs. The registry includes only one practice model that focuses on geriatric mental health. It is included in our resource guide.

The Evaluation Center, Human Services Research Institute, is a SAMHSA funded National Technical Assistance Center that provides useful information and guidance on evidence-based practices in mental health and substance abuse (<http://tecathsri.org>). Staff can provide technical assistance on moving a program toward an evidence-based practice using evaluation and offer numerous specialty toolkits for model replication (e.g. Assertive Community Treatment, ACT). Many of the toolkits and resource materials are available on-line free. The web site includes several models of therapy that focus on geriatric mental health. However, we do not include them in the resource guide because they are treatment modalities rather than program models and the reader can access them through the website.

A more recent effort to build a knowledge base for evidence-based models and practices in geriatric mental health is currently underway. SAMHSA has funded the National Older Adult and Mental Health Technical Assistance Center at Harvard University (Sue Levkoff, Director, personal communication July 2003). The Center provides technical assistance to nine SAMHSA grantees under the “Targeted Capacity Expansion Programs.” They are currently working on plans for providing technical assistance and resources beyond the grantees via a web site.

**Washington State criteria.** For the purposes of the geriatric mental health resource guide, the Washington State Mental Health Division has provided a relatively broad definition for what constitutes “best” and “promising” practices. Best Practices are defined as strategies and programs which are deemed research-based by scientists and researchers through the National Institute of Mental Health, National Institute for Drug Abuse (NIDA), American Psychological Association or National Association of Social Workers, the National Center for Substance Abuse Prevention (CSAP), National Center for the Advancement of Prevention (NCAP), National Office of Juvenile Justice and Delinquency Prevention (OJJDP), National Department of Education (DOE).

For reasons spelled out below, this definition is problematic—especially if the intent of the resource guide is to establish which models of care are to be supported by the Mental Health Division. Promising Practices are practices in areas where there are few programs that have enough outcome data (or have been sufficiently evaluated) to be deemed a best practice. These programs or strategies have some quantitative data showing positive outcomes over a period, but do not have enough research or replication to support generalized outcomes. For reasons spelled out below, this definition is problematic given the current state of the art in geriatric mental health services—especially if the intent of the resource guide is to establish which models of care are to be supported by the Mental Health Division.

**The match of program models with criteria.** In our review of programs, we found a modest evidence base. In some cases, there is empirical evidence about the effectiveness of program models, but there is little empirical evidence about the effectiveness of replications. In other cases, there is a relatively strong evidence-base for a component of the intervention (e.g. specific psychiatric medications for specific diagnoses and symptoms), but little evidence about the effectiveness of the program in which the medication intervention is embedded. We suspect that in the many situations in which there is no evidence supporting the effectiveness of a program, it is because they have not yet been studied or evaluated. Given the modest amount of evidence that was found in our review, we suspect that many well-conceptualized and well-implemented programs exist that do not qualify as “evidence-based”.

Possible circumstances for unevaluated program models are:

- The intervention is new and innovative and not yet well-documented;
- The organization does not have strong ties to a research institution nor organizational resources to evaluate the practice;
- The complexity of the intervention makes it difficult to evaluate;
- The intervention has not drawn the interest of researchers;
- People who run the program are so busy keeping it afloat they haven’t taken time to incorporate a research component;
- The model may not be seen as worthy of study.

A concern is that the above circumstances (with the exception of number 6) could result in an uneven distribution of research evidence across practice model types. This in turn could result in a biased array of practice models classified as “evidence-based”, “best”, or “promising.” A little studied effective practice model would be excluded not based on its inferiority, but, rather, due to its misfortune in not being the subject of an empirical study. While managers of the overlooked program might be criticized for not taking steps to be accountable, realities of the current social service environment also are responsible for this short-coming.

An additional concern is that the “evidence-based” practice movement may be biased against practices that are more difficult to study empirically. Multi-service programs with a mental health component serve as an example. When well-run, these models may significantly increase access to mental health services because mental health services are introduced in a way that is more acceptable to older adult participants than some other models.

#### **WHY WE THINK IT IS PREMATURE TO USE RESTRICTIVE CRITERIA IN SELECTING PROGRAMS FOR A BEST AND PROMISING GERIATRIC MENTAL HEALTH PRACTICE MODELS RESOURCE GUIDE**

We conclude that there is not yet a satisfactory research base for geriatric mental health service models, although the body of evidence is growing. We agree with the recommendation of Rosenberg et al. (2001) who suggest that policy makers “hold off on endorsing specific models and instead support studies of comparative effectiveness” (page 1593). Meanwhile, our task is to select promising practices that are good candidates for

effectiveness studies and for receiving support for the development of their evaluation capacity. This recommendation is closely linked to concerns about how the “best” or “promising” practice will affect the service system. In his recent visit to the State of Washington on August 28, 2003, Greg Teague, national expert on outcome measurement and service system research, stressed that mental health systems use the best available current scientific evidence about the effectiveness of mental health practices. He also pointed out that that does not mean we do not fund services that do not yet have evidence. Indeed, evidence-based practices in geriatric mental health care are in their infancy.

What follows are descriptions of twelve models for geriatric mental health services. They range in their comprehensiveness and organizational structures. They are not mutually exclusive, but provide a range of options for communities who want to develop and/or expand their capacity to provide effective geriatric mental health services. Many promising practices were left out due to time constraints. We apologize if your best or promising practice was overlooked; we hope to include it in the next version of these documents. They are:

- A. Outreach Models
- B. Specialty Community Mental Health Programs
- C. In Home Mental Health
- D. Caregiver Programs
- E. Adult Day Services With Mental Health
- F. Comprehensive, Integrated Health/Mental Health/Long Term Care
- G. Models for Geriatric Clinical Practice Improvement
- H. Multi-Service Programs with Mental Health Component
- I. Support/Self Help Groups and Peer Counseling Programs
- J. Mental Health in Primary Care
- K. Mental Health in Nursing Homes
- L. Geriatric Mental Health Services Improvement through Coalitions, Partnerships and Teams

### ***A. Outreach Models***

“Outreach is an effort to identify older adults in need of mental health or substance abuse services and to help them get what they need” (DSHS, 2002, p. 29). As mentioned earlier, older adults are not likely to seek help for mental health services from mental health clinics or their primary care physicians (DHHS, 2001a). Outreach includes finding older adults who remain invisible to the systems of care that provide the services that they need; case-finding. Both the mental health and aging systems of care rely on passive case-finding efforts to reach at-risk older adults, that is, they wait to be contacted. The most common strategies, such as television advertisements, Senior Information and Referral services, and public education campaigns, depend on the at-risk population’s ability to access services on their own.

Outreach also includes bringing services to older adults who cannot or will not attain services from a more traditional service setting. Providing in-home mental health services is preferable to many older adults who are resistant or unable to travel outside the home. Outreach models are designed to overcome the many individual, provider and system barriers identified previously by reaching out to older adults in need of mental health services in their

own communities and homes. The goal of outreach is to identify vulnerable older adults that do not come to our attention through more traditional avenues and to link them to needed services that help to maintain them safely in their homes.

The Gatekeeper model of case-finding at-risk older adults has been replicated and adapted in many types of communities and systems of care (Jensen, 2002). It is often one component of a larger program of services for older adults. Sometimes the model is adapted to fit a specific target population or setting. Several different outreach models are presented in the guide and highlight the adaptability of the core components of the model.

### ***B. Specialty Community Mental Health Programs***

Specialty Community Mental Health Programs for older adults are marked by their dedication and specialty programming to meet the unique needs of older adults with mental health and substance abuse problems. They typically offer an array of mental health, substance abuse and other social services through collaborations and agreements with other community-based service providers. Some programs are part of a larger hospital system, others are special programs within a community mental health center and others are stand-alone programs. They all share a commitment to providing specialized geriatric mental health services by specially trained staff. The Wrap-Around concept that was developed in the field of children's mental health has been adapted to meet the complex needs of older adults (DHHS, 2002). It is a concept that is just beginning to make its way into the geriatric field and holds promise for improved care on the individual level.

In-Home Mental Health Programs are designed to bring services to older adults in their own homes and communities. Most of the programs are targeted to older adults that have difficulties leaving their homes for services due to their psychiatric and/or physical disabilities.

### ***C. Caregiver Programs***

Approximately one out of every four households in the United States provides care to a relative or friend aged 50 or older (National Alliance for Care giving, 1997). The average age of informal, unpaid primary caregivers is over 60 years old, almost three quarters are women and one third are juggling care giving with paid employment. Many of these caregivers develop stress-related physical and psychological illnesses. Caregivers of persons with dementia are reported to experience greater strain and have more physical and mental health problems than caregivers for persons without dementia (Ory et al., 1999). Several studies report that caregivers' capacities and health may be as important in the decision to place a loved one in a nursing home as the health condition of the person being care for (McFall & Miller, 1992; Pruchno et al., 1990).

The types of caregiver programs vary. They include education and support, concrete assistance, cognitive, behavioral or psychodynamic therapy, coping skill training, and respite care (Gallagher, 1985).

A general conclusion drawn by Ostwald et al., (1999) from the care giving literature is that two qualities of interventions characterize the most successful caregiver programs: 1) that

they be multi-component (e.g. the programs provides support along with education rather than providing support alone), and 2) that they be designed to address particular caregiver situations or behaviors of the person being cared for (e.g. managing behavioral issues of individuals with dementia) rather than taken a general approach.

#### ***D. Adult Day Services with Mental Health***

Adult Day Services (ADS) are comprehensive programs that offer a variety of social and health services in a protective setting. According to the Standards for Adult Day Care, “adult day care is a community-based group program designed to meet the needs of functionally impaired adults through an individual plan of care.” Typically, transportation is provided to participants who come to the center for several hours a day, two to three times a week. Some participants attend five days a week. Most adult day centers operate five days a week during regular business hours. Services include assessment and care planning, nursing, nutrition programs, recreational activities, a lunch meal, exercises, art, music, and assistance with activities of daily living. Some centers provide physical, speech, and occupational therapy and some are designed to provide care for individuals with special categories of mental illness such as Alzheimer’s disease.

ADS have the potential to be beneficial for many older adults with mental illness. The program can offer supervised social interaction and skill building interventions that target behavioral and mood symptoms of Alzheimer’s disease and other mental disorders. They also provide respite for informal caregivers. In Washington State, a majority of the ADS programs offer Alzheimer’s programs or dementia-specific services. Though ADS programs vary in the extent to which they serve individuals with mental disorders and behavioral issues, the majority of participants in a number of Washington State’s programs have a mental disorder. For example, approximately 60% of the Adult Day Health population at Providence ElderPlace Seattle has a mental health diagnosis. The most frequent diagnoses are dementia and depression (personal communication with Ellen Garcia, 2003). ElderHealth Northwest, an ADS provider in Seattle, reports that approximately 37% of its Adult Day Health participants have a mental illness diagnosis and 37% has a diagnosis of Alzheimer’s disease (personal communication with Nora Gibson, 2002).

A number of studies report positive outcomes for older adult participants in ADS. Family members have reported improvement in mood, behavior, and sleep (Zarit et al., 1999; Levin et al., 1989, Gottlieb & Johnson, 1995). Zank and Schacke (2002) reported significant positive effects of day care on well-being and dementia symptoms. There is little evidence of improvement in performance in activities of daily living or behavior problems (Wimo et al., 1993). In addition, to date, there has been little study of the relationship between ADS use and nursing home placement. Two studies report that participation in ADS is not related to decreases in admissions to nursing homes (Hedrick et al., 1993; Weissert et al., 1990). More study is needed before conclusions can be made about the effectiveness of ADS in this regard, since it is possible that ADS will be effective in specific circumstances that need to be better understood. For example, several studies have found that caregivers who use adequate amounts of ADS experience lower perceived care burden and less depression (Gottlieb & Johnson, 1995; Wimo et al., 1993; Zarit et. al,

1998). Since caregiver burnout has been shown to be a factor in predicting nursing home placement, an adequate “dose” of ADS respite may be associated with reductions in caregiver burden and associated nursing home placement. Further study is also suggested because of methodological flaws in many studies of ADS noted by Zarit et al. (1998).

A related issue is how to keep caregivers engaged with ADS so that therapeutic levels of respite are achieved. A study of ten ADS demonstration programs found that programs that provided interaction with caregivers had lower discharge rates than programs that provided respite alone (Henry and Capitman, 1995).

### ***E. Comprehensive, Integrated Health/Mental Health/Long-term Care Programs***

Many older adults with mental illness have co-occurring chronic physical illnesses. In addition, those who are very old are more likely to need assistance with activities of daily living and the support of the long-term care service system than younger populations. Multiple needs require services from multiple providers from different organizations and in various settings. Often older adults with mental illness interact with three service systems: mental health, the aging services network, and primary health care. Unfortunately, the activities of these three social and health service systems are usually poorly coordinated and the experience of the consumer is fragmented. The consequence to the consumer is repetition in information giving, confusion about where to turn for help with specific social and health needs, contradictory instructions for health care, failure to identify important needs, lack of attention to the whole person.

A response to these barriers is comprehensive, integrated care that is provided under the authority of a single organization or administrative authority. Programs of this nature take a variety of forms. Two of the best known programs use capitated financing using Medicare and Medicaid dollars. They are the Social Health Maintenance Organization (SHMO) and the Program for All-Inclusive Care of the Elderly (PACE). Both are federal demonstration projects, though some are becoming established as permanent programs.

### ***F. Models for Geriatric Clinical Practice Improvement***

Systems of quality improvement are essential to any geriatric mental health best practice. Since complete and exact replication of the models described in this guide is not the norm, it is recommended that each case of implementation be monitored to see if practices are implemented as intended and client outcomes meet expectations.

“Clinical Practice Improvement” involves detailed recording and analysis of care process factors, patient factors, and outcomes, with assessment of patient condition occurring at multiple points in time (Bartels et al., 2001). Ideally, the outcome measure has direct utility in delivering care and the measures become a routine part of clinical and administrative practice. This enables mental health providers to identify the aspects of the process of care that are connected to better or worse outcomes.

Outcomes can be used to improve practice in a number of ways:

- To measure the performance of individual providers;



- To measure the effectiveness of a group or team of providers;
- To compare performance of different procedures for a given diagnosis;
- To compare performance of different provider networks for a given diagnosis;
- To profile providers and identify specific providers who excel and those who could benefit from further training;
- To assess the results of individual clinical treatment to date and improve subsequent care (i.e. the clinician compares a client’s condition on the current visit with ratings over time);
- To support formal practice research that addresses specific clinical questions aimed at improving treatments and services, using data from multiple provider networks (Bartels et al., 2001).

A Clinical Practice Improvement model requires “a uniform way to quantify symptoms, behaviors, and functional domains in the medical record so that the Clinical Practice improvement can be conducted in an optimal fashion. This approach also includes a standard approach to rating the specific type of interventions that are provided in psychiatric treatment, allowing for quantification of both process and outcome that can be readily extracted from the chart and analyzed so that effectiveness of practice can be monitored and enhanced” (Bartels et al., 2001, p. 204).

### ***G. Multi-Service Programs with a Mental Health Component***

Multi-service centers, nutrition programs, and senior centers have the potential to increase access to mental health and addiction services by older adults who may avoid traditional mental health service providers due to the stigma of having a “mental illness” or an “addiction”. Older adults may be more comfortable in these community-based social programs, than they are in the offices of specialty health and mental health centers.

“After participating in the program for a while, clients often recall how frightened and ashamed they felt when they first came to the center—ostracized by family and neighbors. At the senior center, however, they found a warm welcome, other people who share their experiences, and the help they needed to change their lives.” (p. 50, DHHS, 2002).

These social centers offer many opportunities for informal health education and outreach for those at risk of health and mental problems. Since participants are likely to be involved in a number of social activities, there are many opportunities for staff to interact with participants informally and develop relationships. As comfort levels of participants increase, they may be more open to health promotion and health education messages. The many services that go on in any one hour at the centers provide considerable anonymity, a condition that may make the many seniors more likely to accept services.

The two multi-service programs presented in the resource guide are Little Havana, Dade County, Florida, and Kit Clark Senior Services, Boston, Massachusetts. Though they serve thousands of persons per year, their caseload for addiction and mental health services represents a fraction of that number.

## ***H. Support/Self Help Groups and Peer Counseling Programs***

Support groups, self-help groups and peer counseling programs provide relatively inexpensive means for older adults to address many mental health needs. They are often used in tandem with formal mental health services. They are especially effective in lowering the risk of serious mental illness for older adults experiencing life transitions, short-term crises and other stressors. Support groups and self-help groups may be more acceptable to older adults than traditional mental health services and they may fill in a gap that exists in the social and health services available to them. They may also prepare participants for professional mental health services that they need.

According to the Administration on Aging, “a support group is comprised of people with a common problem or situation who pool resources, gather information, and offer mutual support, services, or care...Support groups share three basic elements: an intense need expressed by the members; the requirement that members be willing to share personal experiences, and a real or perceived similarity in their suffering.” (p. 44, 2001).

Support groups take a variety of forms. They can be open-ended with no set number of sessions or they may be time limited. They may be led by a trained health professional who is paid a fee or they may be “self-help” where the group is led by a volunteer or peer (these groups are usually free). The topic of the group can be general (e.g. bereavement of any type) or specific (e.g. mental illness or Alzheimer’s disease).

There is some evidence that support groups can be effective, however intervention conditions among the various studies are not consistent. One study showed improved mental health status for participants in of bereavement self-help groups while those in control groups showed deterioration on most mental health indicators (Lieberman & Videka-Sherman, 1986). Researchers found that level of active involvement in the group was important to outcomes for older adults. Another study of the Widowed Persons Service program, which pairs widows with a widow contact who provides emotional and practical support showed promising results. Although, the study found that most women recovered from bereavement with or without help, those receiving the intervention recovered more quickly (Vachon et. al, 1980).

Peer Counseling programs are comprised of older adults, often volunteers, who share similar experiences or are trained to provide limited mental health support. These programs are designed to be mutually beneficial to the peer counselor and the recipient. Peer counseling often takes place in the “recipients” own home through home visits and telephone reassurance. Peer counselors may provide assistance with shopping, travel and other special activities. Many older adults find sharing their inner most feelings and problems with someone their own age or life experiences more acceptable and beneficial than traditional mental health services (DHHS, 2001a). Peer counseling programs are used in many different systems of care including, Long Term Care Ombudsman, domestic violence, elder abuse, and legal services.

Peer counseling programs are often a component of a larger Older Adult Program or agency, and therefore, have not been the focus of research. Many of these programs start through a

grass-roots process often involving a grateful “recipient” of mental health services whom wants to help others in need. Other peer counseling programs begin as a way to fill a gap in existing services. Most peer counseling programs provide limited descriptive information that focuses on “how to develop a program.” Some monitor success through satisfaction surveys, tenure in the program or graduation from the program, or becoming a peer oneself.

The Senior Companion Program is one of the largest peer counseling programs. It is a federally funded program through the National Senior Service Corps (Senior Corps). The program trains individuals that are 55 years of age and older to provide assistance and friendship to homebound elders, generally living alone. This program has been the focus of much research. Some of the findings indicate that, 1) the Senior Companion program has had a positive impact on the agencies, clients and family members/caregivers served by the program, 2) Senior Companions played an important role in expanding the array of independent living services to home-bound elders (RTI, 2003).

The multi-county geriatric peer-counseling program of Skagit Mental Health, Washington (Rogers, LaFollette & Rowe, 1993) began in 1986, to utilize the skills and talents of Senior volunteers who provide home-based supportive services to older adults with mental illness in Skagit, Whatcom, Island and San Juan Counties. Since the program began, staff has assisted many communities throughout Washington State and abroad to develop peer counseling programs with the assistance from their training book, In the Company of their Peers: A geriatric peer counselors training manual (Rogers et al., 1993). An observational study conducted in 1990 (Rogers et al., 1993) revealed that older adults who received peer counseling experienced many different problems or conditions. The most commonly reported were, frequent visits to their doctors (71%), depression (69%), some type of chronic illness (64%), some degree of mental illness (61%), poor eating habits (58%) and conflict with children (36%). The typical contact between the peer counselor and recipient involved companionship, counseling, shared interests, transportation, crisis control and health monitoring to address these and other concerns.

### ***I. Mental Health Services in Primary Care Settings***

Models of mental health service in primary care are increasingly recognized as important for older adults with mental health issues. They are a natural point of access to mental health services for most older adults who visit them regularly. Older adults may prefer to access mental health treatment in primary care clinics because they may be more “user-friendly”. Primary care clinics may also have less stigma associated with them as compared to specialty mental health services. In addition, primary care may be more convenient than specialty care.

Over half of older adults who receive mental health care receive that care from their primary care provider. Models designed to improve mental health services in primary care settings address the well-documented problem of lack of identification and under-treatment of mental health problems in primary care settings and in the community. Typically, these models involve collaborative arrangements between mental health professionals and the primary care physician, nurse practitioner, or physician’s assistant. Some models integrate mental health professionals into the primary care practice, while others have looser affiliations. In all models, mental health professionals assist primary care physicians and their staff by

performing one or more of the following activities: 1) screening, 2) counseling, 3) patient and family education, 4) monitoring compliance with physician advice, and 5) coordination of care. Most models of mental health services in primary care have targeted individuals with depression. There is still some question as to whether this approach can be successful for persons with other major mental disorders such as schizophrenia or Alzheimer's disease.

Models of mental health services in primary care settings fall into three categories: 1) attachment mental health professional, 2) consultation liaison, 3) community mental health teams (Gask et. Al., 1997). The following examples of promising models of mental health services in primary care settings are grouped into these three categories.

#### *Attached mental health professional*

A mental health professional, such as a psychiatrist, nurse, clinical psychologist, or social worker, associated with the practice may screen for mental health problems, conduct psychosocial treatment sessions, and monitor compliance with medications. There is comparatively little teamwork in this model in comparison with the other two types.

#### *Consultation-liaison*

A psychiatrist or mental health professional serves as the mental health specialist for a primary care practice. The specialist collaborates closely with the primary care staff with regular face-face contact. All older adults in need of mental health services are discussed in face-face meetings of the mental health specialist and primary care team. Some patients are treated by mental health specialists only, while others are referred to the mental health specialist for treatment (Gask et al., 1997). The model is designed to enhance the primary care provider's skills in identification and treatment of milder mental disorders and selectively refer older adults with serious mental illness to the specialist.

#### *Community mental health teams*

This model is characterized by psychiatric hospital-based teams that operate within the community. They do geriatric assessments and provide education and consultative services. They refer older adults with mental health care needs to a variety of community resources.

### ***J. Mental Health Services in Nursing Homes***

The prevalence of mental illness, especially depression and dementia, is high in nursing homes. It has been estimated that two-thirds of nursing home residents have some mental disorder or illness (DHHS, 1999). In fact, mental disorders are a key risk factor for institutionalization for older adults (DHHS, 1999). However, few residents in need of mental health services receive them (Lombardo, 1994; Bartels, et al., 2002, DHHS, 2001a).

A number of key policies have contributed to the high rates of mental illness in long term care facilities. The deinstitutionalization movement of the 1960's played a major role in the shift of older adult state psychiatric hospital population to nursing homes. Financing incentives favoring in-patient care over out-patient care also contributed to the trend toward reliance on nursing homes as a care setting for older adults with mental illness. Tragically, nursing homes were ill prepared to care for this difficult population. A key report published by the Institute of Medicine (1986) revealed inappropriate and inadequate care in nursing

homes, including the improper use of seclusions and restraints and psychotropic medications. This report was largely responsible for major nursing home reform. As a result, the Nursing Home Reform Act of 1987 (the Omnibus Budget Reconciliation Act of 1987; OBRA) was passed.

The Pre-admission Screening and annual resident review (PASARR) was intended to improve the overall quality of mental health services to nursing home residents. There has been some debate on whether this has in fact occurred (DHHS, 1999; DHHS, 2002; Bazelon Center for Mental Health Law, 1996; DHHS, 2002; Snowden & Roy-Byrne, 1998). There is evidence to suggest that mental health services remain limited in nursing facilities due to the absence of specialized geriatric mental health providers (Bartels, Moak & Dums, 2002), lack of follow-through with PASARR treatment recommendations (Snowden & Roy-Byrne, 1998), and restricted funding for mental health services in this setting (DHHS, 1999).

The American Geriatrics Society and American Association for Geriatric Psychiatry recently convened an expert panel on improving mental health services in nursing homes (in press). They developed a consensus statement to address this issue, which will be presented in an upcoming issue of the American Journal of the Geriatric Society (in press).

Bartels, Moak and Dums (2002) provide an excellent review on models and outcomes of mental health services in nursing homes. They review extrinsic models that refer to services that are provided to nursing homes by a variety of professionals external to the nursing home itself. They identify three common models of mental health service delivery; 1) psychiatrist-centered, 2) nurse-centered, and 3) multidisciplinary team models.

According to Bartels et al. (2002), there are few well-designed controlled intervention and outcome studies of these models in the literature. Most have methodological limitations that make it difficult to reach consensus on their effectiveness. Still, there is some evidence to suggest that the mere provision of mental health services in nursing homes may lead to improved symptoms and functioning, reduce the use of acute services, improve functioning of nursing home staff, and improve physician's prescribing practices.

We know that nursing homes in Washington State utilize all three models for the delivery of mental health services to their residents. However, they have not been evaluated to determine effectiveness on a program-level or individual level. Several models attempt to change the way nursing homes are structured and function in order to improve the overall care of residents. Two that have been replicated throughout the states and abroad, including Washington State, are GENTLECARE and the Eden Alternative. They are included in the resource guide. These models have not undergone rigorous testing for outcomes, but do have some observational evidence to suggest their effectiveness.

Older adults with mental illness also reside in long-term care residential settings other than nursing homes. They include assisted living facilities, boarding homes, and adult family homes. Unfortunately, there is a paucity of literature on promising or evidence-based practices focused on mental health services in residential long term care facilities, (DHHS, 2001, Bartels, et al., 2002). However, the Washington State Dementia Care Project in

Boarding Homes is included in our *Best and Promising Practices in Geriatric Mental Health Resource Guide* as an example of a local practice that holds promise for improving mental health care for a large population of older adults residing in this type of setting.

### ***K. Geriatric Mental Health Services Improvement through Coalitions, Partnerships and Teams***

There is increasing interest in improving access, quality, and delivery of geriatric mental health services through better coordination and collaboration of service systems and service provider networks by developing coalitions, partnerships and multidisciplinary teams. The National Coalition on Mental Health and Aging, along with its partner, the National Council on Aging, spearheaded the movement on the developing many of these mental health and aging coalitions (NCOA, 1999). DHHS (2001) is promoting four strategies to foster collaboration:

- 1) promote partnerships among mental health, substance abuse, primary care, and aging services at national, state and local levels in order to develop policies and plan programs by developing referral protocols, coordinating care for clients, disseminating research, and sharing best practice information;
- 2) utilize collaborative relationships among a wide range of organizations, such as housing programs, churches, and hospitals to provide continuity of care and more comprehensive services;
- 3) expand and improve case management services for older adults with serious and persistent mental disorders; and
- 4) develop a national demonstration program of local partnerships involving aging, mental health, primary care, substance abuse providers and consumer groups to offer prevention, screening and referral services (p. 62).

Promoting Older Adult Health: Aging Network Partnerships to Address Medication, Alcohol, and Mental Health Problems (DHHS, 2002) provides a list of the known State-level mental health and aging coalitions, therefore, they are not listed in the resource guide--there are many. Washington State has a newly formed coalition, The Washington State Coalition for Aging, Mental Health and Substance Abuse (WSCAMHSA). A major goal of these coalitions is to improve advocacy, access, quality, and service delivery of mental health, aging, and substance abuse services to older adults. The AARP Foundation has published an experienced-based guide from their study of state and local mental health, aging and substance abuse coalition building efforts (2001). Based on the experience of 52 participants from state and local coalitions, including representatives from Pierce County, Washington's Older Adult Group, the guide provides important issues to consider when building a coalition. Issues include getting started, building the momentum, taking off, surviving and thriving and many lessons learned and successes.

Washington State has several local and regional coalitions dedicated to improving mental health services to older adults; however, the effectiveness of these coalitions has not been formally evaluated. Some include broad representation of mental health and aging service providers, while others represent geriatric mental health providers. A short list of some of these coalitions include: King County Geriatric Coordinators, Pierce County's Older Adult Group, and Spokane County's Task for Mental Health and Aging. As mentioned in the

Outreach section, the counties involved in the Community Action Grant, Gatekeeper program replication were required to develop mental health and aging coalitions to adapt the program to fit their communities. The majority of these coalitions are ongoing and have gone on to further improve and expand older adult mental health, aging and social services (for a complete list of these coalitions, see Jensen, 2002).

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**2003 Evidence Based Practices in Geriatric Mental Health**

Websites and Resources with information about evidence-based individual geriatric mental health treatment. Thank you to Dr. Sue Levkoff and the National Older Adult and Mental Health Technical Assistance Center at Harvard University for sharing this compilation.

Name	Organization	Website
Macarthur Initiative Depression Toolkit	The Macarthur Foundation Initiative on Depression and Primary Care	<a href="http://www.depression-primarycare.org/toolkit2.html">http://www.depression-primarycare.org/toolkit2.html</a>
Management of Depression	Intermountain Health Care (IHC)	<a href="http://www.ihc.com/documents/61/cpmdepression.pdf">http://www.ihc.com/documents/61/cpmdepression.pdf</a>
Practice Guideline for the Treatment of Major Depression	American Psychiatric Association (APA)	<a href="http://www.psych.org/clin_res/Depression2e.book.cfm">http://www.psych.org/clin_res/Depression2e.book.cfm</a>
What are the general guidelines for treatment of depression?	Well-Connected	<a href="http://www.well-connected.com/report.cgi/doc08treatguidelines.html">http://www.well-connected.com/report.cgi/doc08treatguidelines.html</a>
Depression in Primary Care (Detection and Diagnosis)	Agency for Healthcare Research and Quality (AHRQ)	<a href="http://hstat2.nlm.nih.gov/hq/Hquest/screen/HquestHome/s/63364">http://hstat2.nlm.nih.gov/hq/Hquest/screen/HquestHome/s/63364</a> then search for keywords
Depression in Primary Care (Treatment)	Agency for Healthcare Research and Quality (AHRQ)	<a href="http://hstat2.nlm.nih.gov/hq/Hquest/screen/HquestHome/s/63364">http://hstat2.nlm.nih.gov/hq/Hquest/screen/HquestHome/s/63364</a> then search for keywords
Clinical Practice Guideline for Management of Major Depressive Disorder in Adults	Veterans' Affairs/ Department of Defense	<a href="http://www.oqp.med.va.gov/cpg/MDD/MDD_Base.htm">http://www.oqp.med.va.gov/cpg/MDD/MDD_Base.htm</a>
Treatment of Depression: Newer Pharmaco-therapies	Agency for Healthcare Research and Quality (AHRQ)	<a href="http://www.ahrq.gov/clinic/epcsums/deprsumm.htm">http://www.ahrq.gov/clinic/epcsums/deprsumm.htm</a>
Late-life depression How to identify its symptoms and provide effective treatment	Geriatrics, 2002: 57, 18-35	<a href="http://www.geri.com/geriatrics/data/articlestandard/geriatrics/072002/9472/article.pdf">http://www.geri.com/geriatrics/data/articlestandard/geriatrics/072002/9472/article.pdf</a>

Choosing Appropriate Treatment for Geriatric Depression	Article: Clinical Geriatrics 2001, 9(5), 30-46	<a href="http://www.mmhc.com/cg/articles/C0105/lavretsky.html">http://www.mmhc.com/cg/articles/C0105/lavretsky.html</a>
Screening for Dementia: Cerebral Dysfunctioning in the Elderly	M. Allan Cooperstein, on the ExpertLaw.com Website	<a href="http://www.expertlaw.com/library/attytarticles/dementia.html">http://www.expertlaw.com/library/attytarticles/dementia.html</a>
Substance Abuse Among Older Adults	USDHHS, SAMHSA, National Clearinghouse for Alcohol and Drug Information (NCADI)	<a href="http://www.health.org/govpubs/BKD250/">http://www.health.org/govpubs/BKD250/</a>
Dementia	American Medical Directors Association (AMDA)	<a href="http://www.guideline.gov/FRAMES/ETS/guideline_fs.asp?guideline=1031&amp;sSearch_string=">http://www.guideline.gov/FRAMES/ETS/guideline_fs.asp?guideline=1031&amp;sSearch_string=</a>
Practice Guidelines for the Treatment of Major Depression	American Psychological Association (APA)	<a href="http://www.psych.org/clinres/depression2e.book.cfm">http://www.psych.org/clinres/depression2e.book.cfm</a>
Screening for Dementia	USDHHS, Office of Disease Prevention and Health Promotion, U.S. Preventive Services Task Force	<a href="http://cpmnet.columbia.edu/texts/gcps/gcps0058.html">http://cpmnet.columbia.edu/texts/gcps/gcps0058.html</a>
Practice Guideline for the Treatment of Patients with Schizophrenia	American Psychiatric Association (APA)	<a href="http://www.psych.org/clin_res/pg_schizo.cfm">http://www.psych.org/clin_res/pg_schizo.cfm</a>
Guidelines for Assessing and Treating Anxiety Disorders	New Zealand Guideline Group	<a href="http://www.nzgg.org.nz/library/gl_complete/anxiety/Anxiety_guideline.pdf">http://www.nzgg.org.nz/library/gl_complete/anxiety/Anxiety_guideline.pdf</a>
Substance Use Disorders	Veteran's Administration/ Department of Defense	<a href="http://www.oqp.med.va.gov/cpg/SUD/SUD_Base.htm">http://www.oqp.med.va.gov/cpg/SUD/SUD_Base.htm</a>
Guidelines for the Support and Management of People with Dementia	New Zealand Guideline Group (NZGG)	<a href="http://www.nzgg.org.nz/library/gl_complete/dementia/index.cfm#contents">http://www.nzgg.org.nz/library/gl_complete/dementia/index.cfm#contents</a>

# Resource Guide

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## *The Gatekeeper Model of Case-Finding*

### **A Best Practice**

#### **Description:**

The Gatekeeper model was created in 1978 by Raymond Raschko, MSW at Elder Services, Spokane Mental Health, Spokane, Washington. It is a community-wide system of proactive case finding to identify at-risk older adults who remain invisible to the service delivery systems created to serve them. Gatekeepers are non-traditional referral sources that come into contact with older adults through their everyday work activities. Gatekeepers are employees of corporations, businesses and community organizations who come into contact with older adults through their everyday work activities. They are trained to look out for signs and symptoms that might indicate an older person needs assistance. Gatekeepers are: Postal Service workers, meter readers, police and sheriff department personnel, bank tellers, cable television installers, resident apartment managers, restaurant employees, residential property appraisers from the county assessor's office, telephone company employees, code enforcement workers, emergency medical response teams of fire departments and ambulance company personnel and many others.

The Gatekeeper model has 3 core program elements: 1) Gatekeeper Recruitment and Training, 2) The Referral System, and 3) The Community Response System.

Gatekeeper Recruitment and Training Over the years, Mr. Raschko, along with the Clinical Director at Elder Services, were primarily responsible for recruitment and training of Gatekeepers in Spokane. It is important to target corporations, businesses and community organizations whose work force has the greatest opportunities for interacting with older adults in the community. Some of the strategies used to recruit potential Gatekeepers include: "cold calls", face-to-face contacts, letters introducing the model and inviting participation, and public media announcements. Experience has shown that persistence is key; telephone calls and face-to-face contacts are the most effective recruitment strategies. Successful recruitment of Gatekeepers usually becomes easier as the program gains visibility in the community. Training issues are presented below.

The Referral System. Communities must have a formalized referral system in place before Gatekeeper recruitment and training begins. Procedures for incoming Gatekeeper referrals must be designated and agreed upon by the community. Daytime, after-hours and weekend telephone numbers must be determined. Telephone screeners must be educated about the

Gatekeeper model, prepared to accept Gatekeeper referrals, and be able to respond appropriately.

In Spokane, when a Gatekeeper identifies an older adult believed to need assistance, they telephone the Senior Information and Assistance (Senior I & A) program at Elder Services. Traditional referral sources (e.g. family, physicians, other agencies) make referrals through the same mechanism. Trained telephone screeners/outreach workers are available 24 hours a day to receive Gatekeeper referrals.

The Response System. Communities must have relevant mental health and other health and social services to offer older adults referred to the program. The community must decide who will respond (e.g. clinical case manager, social worker, nurse, a nurse and geriatric mental health specialist team) once a referral is taken, how the referral response will take place (e.g. home visit, telephone contact, referral to the appropriate agency), and under what conditions (e.g. immediate response, crisis response, refused first contact—return visit). Once contact is made with the older adult, a comprehensive in-home assessment is completed to evaluate the individual's overall needs. Along with input from the older adult, a treatment plan is developed to address their needs. Services are provided from any number of agencies (e.g. mental health case management, chore services, meal service, health services), therefore, prior agreement and coordination with agencies that serve older adults is critical for the successful delivery of appropriate and quality services.

When a Gatekeeper referral is received at Elder Services, a Senior I & A telephone screener/outreach worker reviews the information and determines the next steps. In some situations, the referral information suggests a simple telephone referral to another community agency, for example, when the referral information indicates a higher functioning older adult needs transportation services. The Senior I & A worker will telephone the older adult, provide information about transportation services, and offer information about other senior services. In other cases, the clinical case manager and nurse will make an in-home visit to complete a comprehensive assessment.

After the initial assessment is complete, a clinical case manager is assigned to manage and coordinate the individual's care. A treatment plan is developed, along with input from the older adult and any other collateral supports (e.g. family members, friends, neighbors, and physician). A variety of services available through Elder Services (e.g. Caregiver respite, in-home pharmacy services), as well as other community services are utilized to provide individualized and tailored care. Elder Services has formal contracts with a number of community agencies that provide the ancillary services necessary to maintain the older adult safely and independently in their own home (e.g. Adult Day Health, minor home repair, legal assistance).

1. **Primary purpose:** To identify, refer and treat older adult residents in need of mental health services who reside in urban public housing developments.
2. **Target populations:** The target population is community-dwelling adults over the age of 60 experiencing any, or all, of the following signs or symptoms of distress: a serious and

persistent mental illness, emotional or behavioral problems, suicide risk, poor health, social isolation, abuse or neglect, substance abuse problems, and reluctance or inability to seek help on their own behalf or the absence of someone to seek help for them.

### **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** Qualitative evaluation: recognized as one of eight “exemplary” practices in the delivery of outreach services to older adults by the Western Interstate Commission for Higher Education, a national organization based in Boulder, Colorado.

### **Evidence supporting practice:**

1. **Peer-reviewed research:** The Spokane Gatekeeper program was evaluated in 1994 by researchers from the Washington Institute for Mental Illness Research & Training. The program has been replicated throughout Washington State and beyond. Two reports highlighting the replication of the project in 10 rural areas in Washington State are cited below.
 

Florio, E. R., Dyck, D. G., Rockwood, T. H., Hendryx, M. S., Jensen, J. E. & Raschko, R., Dyck, D. (1996). A model gatekeeper program to find the at-risk elderly: Client characteristics and service needs. *Journal of Case Management*, 5, 106-114.

Florio, E. R., Hendryx, M. S., Jensen, J. E., Rockwood, T. H., Raschko, R. & Dyck, D. G. (1997). A comparison of suicidal and non-suicidal elders referred to a community mental health center program. *Suicide and Life Threatening Behavior*, 27, 182-193.

Florio, E. R., Jensen, J. E., Hendryx, M. S., Raschko, R. & Mathieson, K. (1998). One year outcomes of older adults referred for aging and mental health services by community gatekeepers. *Journal of Case Management*, 7, 1-10.

Jensen, J.E. & Florio, E. R. (1999). Gatekeeper model of case-finding at-risk older adults: Coalition building & community consensus to adopt the model. Process Evaluation Report. SAMHSA, No. P7953314-01.

Jensen, J.E. (2002). Gatekeeper model of case-finding at-risk older adults: Implementation. Process Evaluation Report. SAMHSA, No. P7953314-01.
2. **Other supporting documents:** A training manual was developed by Mr. Raschko to train Gatekeepers (Raschko & Coleman, 1991, manual is available upon request). An ABC World News Tonight video highlighting the program in 1991 is also available. A number of guides to assist communities to adopt the model are available as well as example materials from other Gatekeeper models across the United States.

### **Practice implementation:**

1. **Staffing requirements:** A program coordinator is key to the success and sustainability of the program. The coordinator should have a geriatric mental health background and/or medical background. A multidisciplinary team should be available to address the various needs of older adults referred. Elder Services’ Gatekeeper program has geriatric clinical case managers, nurses, gero-pharmacist, and psychiatrist. They also have formal contracts with other health and social service agencies (e.g. adult day health, respite care, transportation, physician services) to provide comprehensive services.



2. **Training requirements:** The Gatekeeper training sessions, which are held at the workplace, last on average, one hour. The training sessions are kept flexible to accommodate the varied work schedules and time demands of the work force. The training should be adapted to accommodate cultural and language differences. Annual or more frequent re-training is suggested for companies or organizations that experience recurrent turnover of staff.
3. **Cost of Program:** The cost of the program will vary considerably based on the scope of the program and the population base. At a minimum, programs should have a .50 FTE program coordinator, an outreach worker, and geriatric specialists to provide and monitor the care of older adults referred.
4. **Use of Natural Funding:** Programs have utilized multiple funding sources including, federal block grant dollars, Older American's Act dollars, Medicaid for services, discretionary funds.

**Other considerations:**

**Replications:** The Gatekeeper program has been replicated in many counties in Washington State: Grant, Adams, Chelan-Douglas, Lincoln, Kittitas, Okanogan, Garfield, Asotin, Whatcom, Jefferson, Grays Harbor, Lewis, Pierce, Thurston-Mason, and Clark. Other known sites of replication can be found in Arizona, Florida, Hawaii, Illinois, Maryland, Michigan, New Hampshire, Oklahoma, Oregon, Pennsylvania, Wisconsin, Wyoming, Australia, and British Columbia.

**Contact information:**

Julie E. Jensen PhD  
The Washington Institute  
9601 Steilacoom Blvd. SW  
Tacoma, WA 98498-7213  
(253) 756-3988  
Email: [jjensen@u.washington.edu](mailto:jjensen@u.washington.edu)

**Relevant websites:**

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# *Psychogeriatric Assessment and Treatment in City Housing (PATCH)*

## **Best Practice**

### **Description:**

Psychogeriatric Assessment and Treatment in City Housing is an outreach program that utilizes the Gatekeeper case finding strategy and a mobile treatment component, that is based on the Assertive Community Treatment model, to target older adult residents of public housing in need of mental health care. The program began as an NIMH demonstration project in six Baltimore high-rise public housing developments in 1986. The program has been so successful that it now operates in every public housing site in Baltimore, Maryland.

The model has three components: 1) A psychiatric nurse provides education and training to public housing employees (e.g. custodians, maintenance workers, managers) that come into contact with residents. They learn how to recognize changes in a residents behaviors that may indicate signs or symptoms of mental illness. The one-hour training addresses: normal versus abnormal aging, mood disorders, schizophrenia, substance abuse, dementia and death and dying issues. If staff become concerned about a resident then they refer the older resident to the psychiatric nurse for follow-through, 2) The mobile treatment nurse approaches the resident in their home and asks for their participation in a series of tests to assess their mental health status and service needs, 3) if mental health services are needed, a psychiatrist makes a home visit with the nurse and together they develop an ongoing treatment plan (e.g. psychotherapy, medications, service linkages). The nurse continues care with case management and advocacy as needed.

1. **Primary purpose:** To identify, refer and treat older adult residents in need of mental health services who reside in urban public housing developments. A major goal is to link 75% of those in need of care to the geriatric outpatient clinic or other community-based services.
2. **Target populations:** Targets urban public housing residents, sixty-years of age and older. The public housing developments are culturally and ethnically diverse.

### **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** Several published instruments are used to assess pre-post mental health status and outcomes: CAGE questionnaire (alcohol use/misuse/abuse screening), ADL/IADL checklist, Montgomery-Asbery Depression Scale (detects change in mood and depressive symptoms), Brief Psychiatric Rating Scale (BPRS; measures psychiatric symptoms and behavioral disorders), Mini Mental Status Exam.

2. **Qualitative evaluation:** Recognized as one of eight “exemplary” practices in the delivery of outreach services to older adults by the Western Interstate Commission for Higher Education, a national organization based in Boulder, Colorado.

**Evidence supporting practice:**

1. **Peer reviewed research:** Dr. Rabins and colleagues from Johns Hopkins, Center for Research on Services for Mental Illness and Johns Hopkins Hospital have been involved in a large and ongoing investigation of PATCH (Evaluation of Psychogeriatric Outreach in City Housing: EPOCH). They have published a large body of research that show the effectiveness of PATCH in identifying and treating older adult residents of public housing in Baltimore. Their investigations also focus on specific issues facing older adults including, suicide, social isolation, and access to healthcare.

During the first ten months of PATCH, 9.5 percent of older adult residents of four housing units were referred for assessment (Roca et al., 1990). Of those evaluated, 89 percent met criteria for at least one DSM-III-R diagnosis; the majority were previously undiagnosed. Dementia, depressive syndromes, schizophrenia and delusional disorders, and alcohol abuse or dependence were the most common diagnoses. In one study, Rabins and colleagues found that 26 months post referral to PATCH, older adults had significantly lower psychiatric symptoms (lower MADRS and BPRS scores) than a nontreatment comparison group (Rabins et al., 2000). Rabins et al. (2002) also found that 3.2% of African American older adult residents reported suicide ideation. Both depression and anxiety were found to be risk factors for passive suicidal ideation for this group. They found social support and religiosity to be protective factors for suicide ideation.

Roca, RP, Storer, DJ, Robbins, BM, Tlasek, ME, & Rabins, PV. (1990). Psychogeriatric assessment and treatment in urban public housing. *Hospital & Community Psychiatry, 41*, 916-920.

Rabins, B. V., Black, B., German, P. et al. (1996). The prevalence of psychiatric disorder in elderly residents of public housing. *Journal of Gerontology: Med Sci, 51A*, 319-324.

Rabins, PV, Black, BS, Roca, R, German, P, McGuire, M, Robbins, B, Rye, R, Brant, L. (2000). Effectiveness of a nurse-based outreach program for identifying and treating psychiatric illness in the elderly. *JAMA, 283*, 2802-2809.

Robbins, B, Rye, R, German, P, Tlasek-Wolfson, M, Penrod, J, Rabins, PV, and Black, BS. (2000). The psychogeriatric assessment and treatment in City Housing (PATCH) program for elders with mental illness in public housing: Getting through the crack in the door. *Archives of Psychiatric Nursing, 14*, 163-172.

Cook, JM, Pearson, JL, Thompson, R, Smith Black, B, Rabins, PV. (2002). Suicidality in Older African Americans: Findings from the EPOCH study. *American Journal of Geriatric Psychiatry, 10*, 437-446.

2. **Other supporting documents:**

Katz, I. R. & Coyne, J. C. (2000). The public mental health model for mental health care for the elderly. *JAMA, 283*, 2844-2845.

**Practice implementation:**

1. **Staffing requirements:** Nurse with geriatric mental health training, psychiatrist for consultation and home-visits.
2. **Training requirements:** Eight week educational program.
3. **Cost of Program:** Support staff costs are approximately \$100,000 per year.
4. **Use of Natural Funding:** Funding comes primarily from the State Department of Mental Hygiene.

**Other considerations:**

**Contact information:**

Peter V. Rabins, MD  
Phone: (410) 955-6736  
Fax: (410) 614-1094  
Email: [pvrabins@jhmi.edu](mailto:pvrabins@jhmi.edu)

**Relevant Websites:**

[www.jhsp.edu/SMI/Research/summaries/patch/html](http://www.jhsp.edu/SMI/Research/summaries/patch/html)

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## *Rural Elderly Outreach Project (REOP)*

**Description:**

Rural Elderly Outreach Project (REOP) is an assertive outreach model designed to strengthen self-reliance of rural Virginians in caring for older adults, heighten awareness of aging and mental health issues, and to address cultural, ethnic, geographic diversity. It incorporates the Gatekeeper case-finding strategy and utilizes an integrated multiple disciplinary team to develop the individuals care plan. The primary team is made up of psychogeriatric and psychiatric nurses. A social worker, psychiatrist, and gerontologist provide consultation during team meetings.

Upon referral, a nurse and/or psychiatrist will make a home-visit if needed to make a comprehensive assessment. Case management and individualized care is provided in the home as needed.

1. **Primary purpose:** To identify, refer and treat older adult residents in need of mental health services who reside in rural areas of Virginia.

2. **Target populations:** Targets rural residents, sixty-years of age and older in need of mental health services.

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:**
2. **Qualitative evaluation:**
3. **Monitoring:** Sixty-three older adults were served the first year of the project. The primary diagnosis of those referred were, dementia (24%), depression (17%), comorbid dementia-depression (10%), and physical illness precipitating psychosocial crisis (25%).

**Evidence supporting practice:**

1. **Peer reviewed research:**  
Abraham, I.L, Buckwalter, K.C., Snustad, D.G., Smullen, D.E., Thompson-Heisterman, A.A, Neese, J.B. & Smith, M. (1993). Psychogeriatric outreach to rural families: The Iowa and Virginia Models. *International Psychogeriatrics*, 5, 203-211.
2. **Other supporting documents:**

**Practice implementation:**

1. **Staffing requirements:** Multidisciplinary team comprised of nurse with geriatric mental health training, psychiatrist, social worker and gerontologist.
2. **Training requirements:**
3. **Cost of Program:** \$1015 direct cost per patient/year.
4. **Use of Natural Funding:** Kellogg Foundation

**Other considerations:**

**Contact information:**

Ivo Abraham, RN, PhD  
Principal Investigator

**Relevant websites:**

# Iowa's Elderly Outreach Project (IOP)

## **Description:**

Mental Health of Rural Elderly Outreach Project (EOP) is a replication of the Gatekeeper model in rural Iowa (1986). This project was one of the first to formally replicate the model in a rural area. It was designed to identify older adults in need of services and to initiate and coordinate referrals to medical and social service agencies. They provide training to the formal network of service providers in the elderly case management network as well as nontraditional referral sources--Gatekeepers.

Upon referral a nurse makes a home visit or other acceptable site to conduct a comprehensive evaluation. All assessments are reviewed by a multidisciplinary team (three nurses, general medical practitioner, 2 psychiatric CNS's, social worker and psychiatrist) at a weekly meeting and a care plan is developed. Clients, family members and other providers are often involved in the care plan as well.

1. **Primary purpose:** Identify older adult in need of care and link them to services.
2. **Target populations:** Older adults 60 years of age and older who reside in rural Iowa.

## **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:**
2. **Qualitative evaluation:**
3. **Monitoring:** Number of referrals and outcomes are tracked.

## **Evidence supporting practice:**

1. **Peer reviewed research:** Over 800 older adults have been referred to the program in 5 years. Of those referred, 50 percent needed and accepted referrals, 25 percent needed services but refused, and 25% didn't need additional services. In the first two years of the program, 420 older adults were identified, 412 in-home assessments were completed, 232 unserved older adults were enrolled, 67 older adults received aftercare services, and 215 referrals were made.

Abraham, I.L., Buckwalter, K.C., Snustad, D.G., Smullen, D.E., Thompson-Heisterman, A.A., Neese, J.B. & Smith, M. (1993). Psychogeriatric outreach to rural families: The Iowa and Virginia Models. *International Psychogeriatrics*, 5, 203-211.

Buckwalter, K.C., McLeran, H., Mitchell, S. & Andrews, P.H. (1988). Responding to mental health needs of the elderly in rural areas: A collaborative geriatric education center model. *Gerontology & Geriatrics Education*, 8, 69-80.

Buckwalter, K.C., Smith, M., Zevenbergen, P. & Russell, D. (1991). Mental health services of the rural elderly outreach program. *The Gerontologist*, 31, 408-412.

2. **Other supporting documents:**

**Practice implementation:**

1. **Staffing requirements:** Multidisciplinary team comprised of nurse with geriatric mental health training, psychiatrist, social worker and gerontologist.
2. **Training requirements:**
3. **Cost of Program:** \$622 direct cost per patient/year.
4. **Use of Natural Funding:** 3-Year funded project: NIMH, AoA and Iowa DHS.

**Other considerations:**

**Contact information:**

Kathleen C. Buckwalter, RN, PhD  
Principle Investigator

**Relevant websites:**

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*Geriatric Regional Assessment Team  
(GRAT) Evergreen Healthcare*

**Description:**

The Geriatric Regional Assessment Team is a specialized crisis intervention and stabilization service for older adults in King County, Washington. The service is provided by a multidisciplinary team with geriatric specialization. The team offers in-home medical, psychosocial, and functional assessments for adults 60 years of age and older. Specific services include a comprehensive psychiatric, medical, social and functional assessment, crisis intervention and stabilization, prompt referral and linkage to mental health, aging, substance abuse, and health care providers, consultation, care planning, and education of professionals, families, and other care providers, and guardianship evaluations on a fee-for-services basis.

Once an older adult is referred to the GRAT, a comprehensive assessment is completed and the team members educate the older adult, and any family or supports about the diagnosis and medications. Assessment tools used include the Geriatric Depression Scale and the Folstein Mini Mental State Exam. They also refer the individual to appropriate agencies and

support groups depending on their need. The agency that receives the referral develops a more comprehensive long-term treatment plan. The GRAT team remains involved with the older adult and the agency until the crisis is stabilized. The GRAT team makes the majority of their referrals to the Aging and Disability Services Case Management program (Area Agency on Aging), medical clinics, the Alzheimer's Association, Adult Protective Services, in-home mental health services (Evergreen) and physicians.

1. **Primary purpose:** Provide crisis response and stabilization services to older adults in need of mental health services.
2. **Target populations:** The target population is adults 60 years of age and older who are: King County residents, in crisis, probability of mental illness, not enrolled in the King County public mental health system, and not residing in a nursing facility. Also, at least one of the following criteria must be met: physically and/or medically compromised; physically disabled, lacking family/friends able and willing to provide support necessary to ensure health and safety, refusing necessary health, mental health, and/or social services, at risk of involuntary psychiatric hospitalization, and in need of an assessment for differential diagnosis. Serves a diverse population of ethnic minorities including Asians (3%), African Americans (9%), Hispanic (5%), and Native American (0.5%). They are also serving the newly emerging Eastern Europeans immigrants including Russians.

#### **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:**
2. **Qualitative evaluation:** Formal state and national reviews of the program are outstanding.
3. **Monitoring:** Quality assurance case reviews are conducted quarterly and outcomes are service related. Case reviews are held on an ongoing basis and staff participate in quarterly reviews. The state and county also conduct annual quality reviews.

#### **Evidence supporting practice:**

1. **Peer reviewed research:**
2. **Other supporting documents:** Information sheet about the program is available.

#### **Practice implementation:**

1. **Staffing requirements:** The multidisciplinary team is comprised of a registered nurse, geriatric mental health specialists, an occupational therapist, and a psychiatrist.
2. **Training requirements:** Team members develop cultural competence by participating in annual cultural sensitivity training.
3. **Cost of Program:**
4. **Use of Natural Funding:** Services are funded by King County Mental Health (RSN).



**Other considerations:**

**Contact information:**

Karen Kent  
Clinical Supervisor  
Geriatric Regional Assessment Team  
Evergreen Healthcare  
5701 Sixth Ave., South, Suite 502  
Seattle, WA 98108  
(206) 215-2850  
E-mail: [kkent@evergreenhealthcare.org](mailto:kkent@evergreenhealthcare.org)

**Relevant websites:**

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## *Elder Substance Abuse Outreach Program*

**Description:**

The Elder Substance Abuse Outreach Program began as a joint project between Hawthorne Services, a multiservice geropsychiatric organization, and Brattleboro Retreat, an inpatient substance abuse treatment agency. The community-based program started in 1997 and modeled after an assertive outreach program in Connecticut. The program was started to address an unmet need in the community for older adults in need of substance abuse services that were not self-referring to traditional substance abuse programs. Staff believed that specialized services were needed for this population because of the co-occurrence of substance abuse and depression and the resulting social isolation that often follows. It is not a crisis program nor does it provide formal in-patient substance abuse treatment or detoxification, rather it collaborates with community-based services that do. The primary role of the program is to identify older adults in need of substance abuse treatment and to then link them to appropriate services.

The program has three facets of treatment: Identification of older adults at-risk; outreach to older adults in their home by an experienced clinician, and weekly substance abuse therapy and peer support group meetings.

Referrals flow from community organizations and Gatekeepers to Hawthorne. Within 24-hours an outreach worker (either the part-time substance abuse counselor or full-time social worker with substance abuse expertise) makes an initial contact to the older adult's home. It

is customary to make numerous home visits before the older adult accepts the need for intervention. An initial assessment is conducted using the MAST-G for substance abuse screening, as well as a depression screen.

If substance abuse is an issue then weekly therapy and psycho-educational groups with peers is recommended. The sessions focus on physical and psychological consequences of addiction. The emphasis is on understanding, resource linkage, and social connections rather than abstinence. The goal of these groups is to move the older person along toward recognizing the substance abuse problem and to link them to more formal services.

Peers are an important component of the program. Older adult volunteers are trained to support participants with emotional problems or depression that often co-occur with substance abuse. They are trained and meet monthly with clinical staff for support.

1. **Primary purpose:** To provide whatever substance abuse and mental health services are needed to keep older adults active and at home as long as possible and to provide care to those who would otherwise be underserved.
2. **Target populations:** The target population is adults 60 years of age and older who have a substance abuse problem. Chicopee is primarily Caucasian and African American, however, there is a growing Hispanic population.

#### **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:**
2. **Qualitative evaluation:** Participant satisfaction surveys have been completed although no data is available.
3. **Monitoring:** The program is licensed and monitored by the Department of Mental Health.

#### **Evidence supporting practice:**

1. **Peer reviewed research:**
2. **Other supporting documents:** Highlighted in *Promoting Older Adult Health: Aging Network Partnerships to Address Medication, Alcohol, and Mental Health Problems*, DHHS, 2002.

#### **Practice implementation:**

1. **Staffing requirements:** A certified alcohol and substance abuse counselor is need for the success of the program. A part-time substance abuse outreach counselor (a social worker with substance abuse credentials) and full-time social worker with substance abuse expertise staff the program. A substance abuse counselor that speaks Spanish is available to work with the Hispanic older adults when needed.

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2. **Training requirements:** Expertise in substance abuse among older adults. Program staff conduct ongoing training to their gatekeepers and other community groups on the prevention, detection, and treatment of alcoholism and depression among the older adult population. Staff also provide consultation to agencies and service providers who seek information and advice on issues of substance abuse and aging.
3. **Cost of Program:**
4. **Use of Natural Funding:** Sources of funding include Brattleboro, direct fund-raising events, grants from the area agencies, and the Center for Community Recovery Innovations (public housing).

### **Other considerations:**

### **Contact information:**

Jim Callahan [www.HawthornServices.org](http://www.HawthornServices.org)  
Maureen Perreault  
Hawthorne Services, Inc.  
93 Main St.  
Chicopee, MA 01020  
(413) 592-5199  
E-mail: hawthorn99@aol.com

### **Relevant websites:**

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# *Center for Older Adults and Their Families*

### **Description:**

The Center for Older Adults and Their Families is the geriatric speciality service of the Gouverneur Diagnostic and Treatment Center's Department of Behavioral Health, Gouverneur Hospital. The hospital is part of the larger New York City Health and Hospitals Corporation and is affiliated with New York University's Bellevue Medical Center.

The program components include: an older adult outreach team that make initial home visits for assessment and engagement, a clinic program that offers assessment, evaluation, therapy, and case management, a day treatment program with a comprehensive array of services plus activities in a therapeutic milieu, and psychiatric consultation for the nursing facility.

The outreach component relies on staff visiting homes, including public housing, senior centers, and other facilities, to increase awareness of mental health services through education and consultation. The focus is on reducing the stigma associated with mental health and services. Referrals come from primary care physicians, in-patient psychiatric facilities, and from friends and family members.

Once an older adult is referred to the program a comprehensive mental health and substance abuse assessment is completed by a multidisciplinary team. The psychosocial assessment evaluates current and past biological, psychological, and social functioning. The CAGE is used to assess substance abuse for the older adults. If available, families are encouraged to take part in the assessment process as well with special focus on their family roles and dynamics. A cultural assessment focuses on immigration status and cultural beliefs and practices.

The team develops a family-centered treatment plan based on the assessment and the individuals biological, psychological, social and family functioning. The Center provides mental health services in-home, on-site and in a Senior Center. On-site services include day treatment; a 5-hours/day program in a therapeutic environment. Individual psychotherapy sessions are available to those not appropriate or comfortable with day treatment. Services offered in the Senior Center (Grand Coalition of Seniors at Grand Street) are provided by an on-site staff member. This staff conducts assessments and provides assessments and counseling. Services are offered in many languages (English, Spanish, Mandarin, Cantonese, Portuguese, and Slovak) and in many ways to reflect the cultural diversity. For example, the weekly staff and client day treatment meetings are conducted in three languages which are rotated throughout the period. This has increased meeting participation.

Upon successful treatment older adults are linked to other community-based programs and services. The Center has close ties to many community agencies and advocacy groups through written agreements, including the Inter-Agency Council of the New York City Department of Aging and the Manhattan Geriatrics Committee.

1. **Primary purpose:** To provide comprehensive geriatric mental health services for older adults and their families.
2. **Target populations:** Program targets adults 55 years of age and older in need of mental health services and their families who reside in urban Manhattan. The target population is very diverse and includes Caucasians, Hispanics, African Americans and well as more recent immigrant populations from Asia, Russia, Latin America and Europe. Cultural competence is a primary feature of this program.

#### **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** The Center is just starting to use the Brief Symptom Inventory at pretreatment and at 6 month followups. No data is currently available however.

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2. **Qualitative evaluation:** Satisfaction surveys indicate that participants overwhelmingly (85%) report that treatment helped them. Seventy-five percent of participants report that the psychotherapy services helped them.
3. **Monitoring:** The program is licenced, certified and monitored by the State and reviewed by the New York City Department of Mental Health.

### **Evidence supporting practice:**

1. **Peer reviewed research:** A number of articles highlight various aspects of the program.  
Sullivan, M. A. (1991). The homeless older woman in context: alienation, cutoff and reconnection. *Journal of Women and Aging*, 3.  
Sullivan, M.A. (Winter, 1997-1998). Look back and wonder: Developing family oriented mental health programs for the elderly. *AFTA Newsletter (American Family Therapy Academy)*, 70, 23-28.  
Wong, G. (1993). The cross cultural group: A multilingual, multicultural group. *Pride Institute Journal of Long Term Human Health Care*, 12.
2. **Other supporting documents:** Descriptive brochures, the family evaluation (Genogram), the cultural assessment, the substance abuse evaluation and the treatment plan review are available upon request.

### **Practice implementation:**

1. **Staffing requirements:** The multidisciplinary team is made up of a half-time psychiatrist, social workers, psychologists, and nurses.
2. **Training requirements:** Staff has extensive training in geriatric mental health, health and disabilities.
3. **Cost of Program:**
4. **Use of Natural Funding:** Medicare/Medicaid will cover 100% of the cost of care. Private insurance will cover part or all of the cost of care in most situations. A sliding fee scale is utilized for individuals without any insurance coverage.

### **Other considerations:**

#### **Contact information:**

Gouverneur Dept. of Behavioral Health  
Center for Older Adults and Their Families  
Edgar Velasquez, MD  
227 Madison St., #397  
New York, NY 10002  
(212) 238-7384

#### **Relevant websites:**

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## Older Adult Outreach and Education Service

### **Description:**

The Older Adult Outreach and Education Service offers inpatient and outpatient substance abuse and mental health treatment, counseling and assertive outreach with a special focus on older adults with a primary substance abuse problem. Chelsea Community Hospital operates the Outreach program as well as a substance abuse outpatient treatment program, Older Adult Recovery Center. The University of Michigan Turner Geriatric Clinic and Neighborhood Senior Services, a non-profit social services agency, work closely with the two programs to provide seamless and comprehensive community-based services to Ann Arbor's Seniors.

The Geriatric Clinic, the neighborhood services agency, and other aging service providers make referrals to the Older Adult Outreach and Education Service program to meet with older adults in their homes. Other referrals come from family members, physicians, home care aides, or other health care workers, the legal system and other social service agencies. Outreach services are available for older adults who cannot seek services on their own or who are unwilling to accept services. A social worker from the Neighborhood Senior Services links older adults to appropriate resources and/or services.

The hospital also offers inpatient, outpatient, day treatment, family therapy, peer counseling and group psycho-educational services about substance abuse and addiction. The Turner Geriatric Clinic provides comprehensive geriatric health, health promotion, learning programs, and community resource information. The Neighborhood Senior Services offers an array of supportive services, including, home-chore assistance, transportation, volunteer services, and resource advocacy (case management and entitlement assistance).

1. **Primary purpose:** To identify, refer and treat older adult residents in need of substance abuse and mental health services who reside in Ann Arbor, Michigan.
2. **Target populations:** Targets older adults with substance abuse problems.

### **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:**
2. **Qualitative evaluation:**
3. **Monitoring:** Primarily service-related. Numbers of older adults receiving new services indicate success. Data are reported in quarterly reports, including demographic data on race, ethnicity, gender, age, income, disability status, and locale. The State agency is responsible for monitoring and evaluating the program.

**Evidence supporting practice:**

1. **Peer reviewed research:**
2. **Other supporting documents:**

**Practice implementation:**

1. **Staffing requirements:** The Older Adult Outreach and Education Service has a half-time staff person with substance abuse expertise.
2. **Training requirements:** Staff provide substance abuse training to it's many community partners. It is important to have a training fully versed in substance abuse prevention and treatment among older adults, as well as mental health and other health and social issue.
3. **Cost of Program:**
4. **Use of Natural Funding:** Federal block grant dollars from the State fund the outreach component. Medicare, Medicaid, private insurance and some State funding pay for treatment services.

**Other considerations:**

**Contact information:**

Jeff Smith  
Older Adult Outreach and Education Service  
Chelsea Community Hospital  
955 West Eisenhower Circle, Suite H  
Ann Arbor, MI 48103  
(734) 665-5070  
E-mail: [jsmith@cch.org](mailto:jsmith@cch.org)

**Relevant websites:**

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## Elders Wrap-Around Team

### **Description:**

This project is an expansion of existing geriatric mental health services at Riverbend Community Mental Health, Elder Services. Riverbend Elder Services has grown since its inception in 1993. It has a staff of 11 that provides psychosocial and psychiatric assessment and evaluation; counseling for groups, individuals, couples, and families, medication assessment and monitoring; case management; education and workshops; information and referral to community resources; outreach; and consumer advocacy. The Elders Wrap-Around Team provides coordination of a wide range of services that are needed by the target population. The Wrap-Around Team includes representatives from 12 core agencies who meet for two hours each month to discuss specific cases and service issues. Providers from 40 other agencies are invited to the table when a case warrants additional expertise. The older adult and family members or supportive others are also encouraged to attend the meetings.

The Wrap-Around concept centers around an older adults strengths, needs, and preferences. The goal is to maintain the older adult in their own home and community safely and independently as long as feasible. Team services include community education, training of team members and the agency network on mental health and aging issues, screening for depression, memory loss, anxiety and substance abuse. Referrals originate from the agencies involved as well as physicians, hospitals, first responders, families and an older adult themselves. Treatment plans are developed by the older adult and the team. It may involve agency specific treatment (mental health services) or an array of community-based services (e.g. chore services, home-delivered meals, pharmacy).

1. **Primary purpose:** To improve the linkages among community agencies and to develop collaborative relationships to provide greater access, coordination and quality services to older adults and their families.
2. **Target populations:** The target population is adults age 60 and older that have service needs in at least 3 different life domains.

### **Evaluating this practice:**

The program is currently being evaluated.

1. **Outcome measures used to evaluate practice:** Unknown.
2. **Qualitative evaluation:** Descriptive data available indicates that hospital admissions have declined and the length of stays have decreased. The number of agencies that have joined the team have increased significantly since the beginning of the program. This has also resulted in more referrals to the participating Wrap-Around Team agencies. After the first year and a half, the program served 18 consumers and their families.



3. **Monitoring:** The program is monitored by the program staff and agency.

**Evidence supporting practice:**

1. **Peer reviewed research:** Unknown.
2. **Other supporting documents:** The program is included in this report as a promising practice. US Department of Health and Human Services (2002). Promoting older adult health: Aging network partnerships to address medication, alcohol, and mental health problems. (DHHS Publication No.(SMA) 02-2628). Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

**Practice implementation:**

1. **Staffing requirements:** Staff recommend that a program coordinator (at least half time) is dedicated to the program. The coordinator is responsible for program design and maintenance, recruiting agencies, and leading team meetings.
2. **Training requirements:** Education and training opportunities are offered through presentations and workshops and target consumers, family members, caregivers, students, professionals and others interested in improving services to older adults. Training focuses on the physical, emotional and social aspects of aging and service delivery.
3. **Cost of Program:** The cost of a coordinator position, staff time for meetings and collaboration. Other costs are minimal. Cost will vary by scope and program.
4. **Use of Natural Funding:** The State funds the coordinator position. Services are billed by each agency involved in service provision; typically services are reimbursed through Medicaid, Medicare and other in-kind contributions, flexible funding and small grants.

**Other considerations:**

Elders Wrap-Around was recognized for its leadership by the National Council for Community Behavioral Health Care for Special Programs, in 2000.

**Contact information:**

Jeanne Duford  
Elders Community Coordinator  
Riverbend Community Mental Health  
PO Box 2032  
Concord, NH 03302-2032  
603-228-2101

**Relevant websites:**

[www.riverbendcmhc.org](http://www.riverbendcmhc.org)

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# The In-Home Mental Health Program

## **Description:**

The In-Home Mental Health Program provides mental health services to older adults in their own homes, adult family homes, assisted living facilities and nursing homes. A multidisciplinary staff provides the following services: assessment and diagnosis, individual therapy, assessment and medication evaluation by an ARNP/Psychiatrist, medication management by psychosocial nurses, social work-case management services, coordination of mental health and medical care, transition to outpatient mental health services, consultation to assisted living facilities, adult family homes and nursing homes, and telephone crisis services 24 hours a day.

Older adults are eligible for in-home services if they meet the following criteria: experience signs and/or symptoms of depression, a thought disorder, dementia, mania or anxiety/panic disorder; are home bound due to a psychiatric or medical condition; and agree to receiving services. Referrals to the program can originate from any source. Program staff recommend that the mental health services be discussed with the potential client prior to referral.

1. **Primary purpose:** To provide a coordinated and comprehensive array of mental health and health services to home bound older adults.
2. **Target populations:** Older adults whose mental and/or physical illnesses or disabilities prohibit them from utilizing traditional outpatient mental health services in King and Snohomish County, Washington.

## **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:**
2. **Qualitative evaluation:**
3. **Monitoring:**

## **Evidence supporting practice:**

1. **Peer reviewed research:**
2. **Other supporting documents:** Information sheet about the program is available.

## **Practice implementation:**

1. **Staffing requirements:** Masters prepared therapists, social workers, psychosocial nurses, ARNPs and psychiatrists.
2. **Training requirements:** Staff has extensive training in geriatric mental health, health and disabilities.

3. **Cost of Program:**

4. **Use of natural funding:** Medicare/Medicaid will cover 100% of the cost of care. Private insurance will cover part or all of the cost of care in most situations. A sliding fee scale is utilized for individuals without any insurance coverage.

**Other considerations:**

**Contact information:**

In-Home Mental Health  
2414 SW Andover Street, D-120  
Seattle, WA 98106  
(206) 923-6300

**Relevant websites:**

[www.evergreenhealthcare.org](http://www.evergreenhealthcare.org)

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*Family Caregiver Counseling Service—  
Evergreen Healthcare, King County*

**Description:**

This is a specialized outreach therapy service provided by the Geriatric Regional Assessment Team that consists of a registered nurse, geriatric mental health specialists, an on-call occupational therapist, and a psychiatrist. The team works collaboratively to provide 1) one to five in-home sessions of brief counseling for caregivers who meet the criteria for eligibility; 2) referral to community services, including support groups and respite care; 3) education and support on specific emotional issues experienced by the caregiver. Counseling, education, and support focuses on problem solving, self-care, stress management, and positive change.

1. **Primary purpose:** .to provide counseling to family caregivers who need counseling secondary to their caregiver role and are unable or unwilling to go to a community counselor.
2. **Target populations:** Adults in King County who are the informal/unpaid primary caregiver of an individual 60 years of age or older or any adult, age 60 or older, who is the informal/unpaid primary caregiver of an individual (under the age of 19 or over the

age of 60) who has mental retardation and related development disabilities; individual with the greatest social and economic need; not residing in a nursing home.

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** .
2. **Qualitative evaluation:** .

**Evidence supporting practice:**

1. **Peer reviewed research:**
2. **Other supporting documents:**

**Practice implementation:**

1. **Staffing requirements:** a registered nurse, geriatric mental health specialists, an on-call occupational therapist, and a psychiatrist.
2. **Training requirements:**
3. **Cost of program:** Unknown
4. **Use of natural funding:** Seattle-King County Aging and Disability Services through a national Family Caregiver Support Grant.

**Other considerations:**

There is no fee for eligible caregivers but only a limited number of caregivers can be served.

**Contact information:**

**Relevant websites:**

[www.evergreenhealthcare.org](http://www.evergreenhealthcare.org)

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*Resources for Enhancing Alzheimer's  
Caregiver Health (REACH)*

**Description:**

REACH is a unique, multisite research program sponsored by the national Institute on Aging and the National Institute on Nursing Research. It is occurring at six sites: Boston,

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Birmingham, Memphis, Miami, Palo Alto, and Philadelphia. Interventions include: 1) individual information and support strategies, 2) group support and family systems therapy, 3) psychoeducational and skill-[based training approaches, 4) home-based environmental interventions, and 5) enhanced technology support systems Schulz et. al, 2003). The goal of all the interventions is to change the nature of specific stressors such as problem behavior of the care recipient, their appraisal, and the caregiver response to the stressors.

1. **Primary purpose:** to carry out social and behavioral research on interventions designed to enhance family caregiving for Alzheimer's disease (AD) and related disorders; to test the effectiveness of multiple different interventions and to evaluate the pooled effect of REACH interventions overall.
2. **Target populations:** family caregivers of persons with AD at the mild or moderate level of impairment.

### **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** caregiver burden, caregiver depression.
2. **Qualitative evaluation:**

### **Evidence supporting practice:**

1. **Peer reviewed research:** Schulz, R., Burgio, L., Burns, R., Eisdorfer, C., Gallagher-Thompson, D., Gitlin, L.N., & Mahone, D.F. (2003) Resources for Enhancing Alzheimer's Caregiver Health (REACH): Overview, site-specific outcomes, and future directions. *The Gerontologist*, 43(4), 514-520.
2. **Other supporting documents:** Training manuals, detailed treatment manuals, certification procedures

### **Practice implementation:**

1. **Staffing requirements:**
2. **Training requirements:**
3. **Cost of program:**
4. **Use of natural funding:**

### **Other considerations:**

**Contact information:**

Richard Schulz, PhD  
University of Pittsburgh  
121 University Place  
Pittsburgh, PA 15260  
schulz@pitt.edu

**Relevant websites:**

<http://www.edc.gsph.pitt.edu/reach/>

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## *Senior Services Caregiver Outreach and Support Program—Seattle/King County*

**Description:**

Caregiver advocates help caregivers identify community resources, select the best options, and assist in securing needed services. Advocates make home visits and give workplace or community presentations on caregiver resources, long distance caregiving, paying for care, and legal issues for caregivers. Additional sources of support include 1) the program's Online Journal where caregivers can read and write daily accounts by other caregivers about their daily experiences via the internet and 2) a caregiver message board.

1. **Primary purpose:** to provide support for unpaid family caregivers by helping them identify community resources, select the best options and assist in securing needed services for themselves and the person they care for
2. **Target populations:** Anyone caring for a person 60 years old or older or any person 60 years old or older caring for a child under the age of 19.

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** Caregivers utilize community support services. Caregivers report that support services helped them be a better caregiver
2. **Qualitative evaluation:** Anonymous written survey. Review of case records.

**Evidence supporting practice:**

1. **Peer reviewed research:**

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2. **Other supporting documents:** Brochures, caregiver kits, on-line database of community resources, website, monthly reports are generated from client records maintained in a Microsoft Access database

### **Practice implementation:**

1. **Staffing requirements:** 3 FTE Caregiver Specialists, 1.3 FTE Information and Assistance Advocates and .2 FTE Data Manager.
2. **Training requirements:** All Caregiver Advocates have at a minimum a relevant bachelor's degree, 5 years of experience and are Certified Information and Referral Specialists, Ageing Emphasis. All participate in continuing education and in-service training.
3. **Cost of program:** The cost of the program in 2003 will be approximately \$250,000.
4. **Use of natural funding:** funded through a National Family Caregiver Support Program Grant allocated through Aging and Disability Services, the local Area Agency on Aging.

### **Other considerations:**

#### **Contact information:**

Eileen Murphy, Associate Director  
Senior Services I&A Project  
2208 2<sup>nd</sup> Avenue, Suite 100  
Seattle, WA 98121  
(206)727-6235  
[Eileenm@seniorservices.org](mailto:Eileenm@seniorservices.org)

#### **Relevant websites:**

<http://www.seniorservices.org/caregiver/caregiver.htm>

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# The SHARE Model

## (Specialized Help for Alzheimer's in a Residential Environment)

### **Description:**

Though this model is housed in a residential care setting, the practice is adaptable to a free-standing adult day Center where transportation is provided. The model was developed to address the needs of individuals with moderate dementia. The program runs on weekdays, 6 hours per day. The approximately 50 participants experienced discrete structured activity periods for welcoming/orientation, therapeutic activities, socialization, toileting, lunch, and snacks. The program provides nursing, social work, therapeutic recreation, dietary services, and rehabilitation services. Therapeutic activities include cognitive and sensory stimulation, exercise and movement programs, music and rhythm, and reminiscence.

1. **Primary purpose:** “to encourage association, recall, and reminiscence; provide a vehicle for thought and communication; promote socialization and a sense of purpose and belonging; reinforce appropriate behavior; maximize and maintain ADL skills; and facilitate environmental awareness and reality orientation in the patients.” (Grower et. al., 1994)
2. **Target populations:** individuals with moderate dementia who are able to engage in the program and do not require frequent one-on-one interventions for aberrant behavior.

### **Evaluating this practice:**

1. **Outcome measures used to evaluate practice**
2. **Qualitative evaluation** showed that participants, staff, and families were satisfied with the program, that the program encouraged recall, humor, familiarity, and affection; the program offered respite to the usual caregivers.

### **Evidence supporting practice:**

1. **Peer reviewed research:** Grower, R. & Frazier, C. (1990). Applying a community based day program to a nursing home setting. Paper presented at the Northeastern Gerontological Society Conference, New Haven, CT.
2. **Other supporting documents:**



**Practice implementation:**

1. **Staffing requirements:** a program coordinator supervises daily operations and clinical aspects of the program; nursing aides provide direct care; adjunct staff.
2. **Training requirements:**
3. **Cost of program:**
4. **Use of natural funding:**

**Other considerations:**

**Contact information:**

Morningside House  
1000 Pelham Parkway  
Bronx, New York 10461  
718-409-8200

**Relevant websites:**

[www.aginginamerica.org](http://www.aginginamerica.org)

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## *On Lok Senior Services Program Day Health Center*

**Description:**

The On Lok Senior Health Services Day Health Center is located in San Francisco, California. It is one component of a comprehensive a consolidated model similar to the Program for All-Inclusive Care for the Elderly described in another section of this guide.

A multidisciplinary team serves as a case manager for each patient; the team includes physicians, nurse practitioners, nurses, social workers, recreation/occupation therapists, home health aides, dieticians, and drivers. The program transports some clients to adult day care daily. Nutritionally balanced hot ethnic meals and nutritious snacks are served during each session. Social and health care services include monitoring health status, assistance with medications, personal care, health education, physical therapy, occupational therapy, speech therapy, group exercises, assistance with obtaining therapy equipment, dietary consultation, psychosocial assessments, individual and family counseling, support groups, and recreation.

1. **Primary purpose:** to help the frail elderly and disabled adults maintain or restore their health so that they can remain in the community with their families as long as possible
2. **Target populations:** must be 55 years old or older and living in San Francisco; experiencing ongoing medical problems, memory loss, and/or need daily help with bathing, walking, eating or dressing; and, may be considering a nursing home but prefer to remain at home

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice** rate of hospital use, length of hospital stays
2. **Qualitative evaluation**

**Evidence supporting practice:**

1. **Peer reviewed research:** Bodenheimer, MD, Thomas; “Long-Term Care for Frail Elderly People — The On Lok Model,” *The New England Journal of Medicine*, October 21, 1999, pp. 1324-1328. Robinson, G.K. (1990b). The psychiatric component of long-term care models. In B.S. Fogel, G.L. Gottlieb, & A. Furino (Eds.), *Mental health policy for older Americans: Protecting minds at risk* (pp. 157-178). Washington, DC: American Psychiatric Press. O’Malley, Kate and Sara Brooks; “Caring the On Lok Way,” *Geriatric Nursing*, March/April 1990, pp. 64-66.
2. **Other supporting documents:** In a 1993 study, savings to Medicare were estimated to be 14 percent to 39 percent when compared to fee-for-service. PACE also has a lower average number of hospital days than does the general Medicare population. This rate is notable primarily because the general Medicare population includes people who are well and those who are sick - unlike PACE, which includes only the very ill and frail, and a majority of patients who have many serious illnesses.

On Lok gained “organization of the year” honors in the Public Health Heroes program, University of California, Berkeley, for its contribution to promoting the health of older adults.

**Practice implementation:**

1. **Staffing requirements:**
2. **Training requirements:**
3. **Cost of program:**
4. **Use of natural funding:**

**Other considerations:**

**Contact information:**

[www.onlok.org](http://www.onlok.org)

**Relevant websites:**

[info@onlok.org](mailto:info@onlok.org) <[info@onlok.org](mailto:info@onlok.org)>

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## *Kaiser Permanente Social Health Maintenance Organization*

**Description:**

This S/HMO plan offers the full range of medical benefits that are offered by standard HMO's plus chronic care/ extended care services. The organization received extra Medicare capitation to expand long-term care services. Enrollees are charged higher premiums that make them eligible for an expanded array of long-term care benefits that go beyond the usual Medicare long-term care benefit. The expanded part of services is usually community-based. A dollar limit on long-term care services is set along with strong oversight by a case manager.

Strengths of this model, according to Dowd et. al. (1999) are that it combines “the authorization and provision of both acute care services and long-term care under one organizational model allowing for better coordination between service providers and a broader scope of control for the organization as a whole.” (p.11) Also it places “the organization at risk for the cost of acute and long-term services covered by the plan.” This creates a strong financial incentive “to ensure that care is provided in the least costly environment that is able to meet the member’s needs.” (p.11)

1. **Primary purpose:** to integrate medical, social and long term care services and long term care services within a capitated managed care framework and to keep functionally impaired older adults living at home as long as possible.
2. **Target populations:** individuals over 65 years of age and is enrolled in Medicare Part A and Part B who live in the Kaiser Permanente S/HMO service area and qualify for nursing home certification. Criteria may include “needing daily ongoing assistance from another person with one of the following activities of daily living: walking or transferring indoors, eating, managing medications, controlling difficult or dangerous behavior, controlling bowels or bladder, or the need for protection and supervision because of confusion or frailty (Official U.S. Government Site for People with Medicare, 2003)”. Not for those with end-stage renal disease or for those who reside in an institutional setting.

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:**
2. **Qualitative evaluation**

**Evidence supporting practice:**

1. **Peer reviewed research:** S/HMOs are in their infancy. They are evolving and under investigation. We feature Portland's Kaiser Permanente because it includes behavioral factors in its assessment for service eligibility and because it is in a family of managed care interventions to "keep an eye on", given their comprehensive nature. Evaluation of cost savings for a similar program in Minneapolis run by the same parent company, showed increased spending for the S/HMO as compared to a traditional HMO. Possible explanations offered by Dowd et. al. (1999) are that S/HMO membership led to increased salience of medical problems for enrollees receiving the extended care benefit, the transportation benefit may have improved access to physicians and clinics, and changes in practice patterns. Indeed, Dowd argues that higher expenditures do not imply that the S/HMO failed to provide services valued by the members. A qualitative study of the termination of the S/HMO in Minnesota found that at risk elderly were receiving fewer home care services, their family caregivers reported increased burden and stress, and they had more out-of-pocket expenses (Fisher et. al., 1998).

Dowd, B., Hillson, S., VonSternberg, T., Fischer, L.R. (1999). S/HMO versus TEFRA HMO enrollees: analysis of expenditures. *Health Care Financing Review*, 20(4), 7-23.

Enguidanos, S.M., Gibbs, N.E., Simmons, W.J., Savoni, K.J., Jamison, P.M., Hackstaff, L., Griffin, A.M., Cherin, D.A. Kaiser Permanente community partner's project: Improving geriatric care management practices. *Journal of the American Geriatric Society*, 51(5), 710-714.

2. **Other supporting documents:** In 1996, the Health Care Financing Administration evaluated the 4 "first generation" S/HMO demonstration projects, one of which was the Kaiser Permanente S/HMO. Evidence that S/HMOs were less costly than fee-for-service were mixed. No improvements in mortality or active life expectancy were demonstrated; however, frail S/HMO enrollees were more satisfied than their fee-for-service comparisons with costs and benefits of care (Vladeck, 1996).

Vladeck, B.C. Testimony on Long Term Care Options: PACE and S/HMO. Before the House Ways and Means, Subcommittee on Health, April 18, 1996.

**Practice implementation:**

1. **Staffing requirements:**
2. **Training requirements:**

3. **Cost of program:**

4. **Use of natural funding:**

**Other considerations:**

Only a minority of the enrollees are poor and in need of long-term care; Kaiser Permanente, Portland, Oregon includes needing assistance in controlling difficult or dangerous behavior as one of the criteria

**Contact information:**

**Relevant websites:**

<http://www.dhs.cahwnet.gov/director/OLTC/html/shmo.htm>

<http://www.hhs.gov/asl/testify/t9604181.html>

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## *Program for All-Inclusive Care of the Elderly (PACE): Providence ElderPlace*

**Description:**

PACE is a partnership between the federal government and the private sector. It uses a coordinated set of services that include both medical and social care services delivered at a day health center. It is characterized by interdisciplinary teamwork and has an onsite staff physician. Many programs purchase a variety of in-home services. It provides a full range of medical, social, and long-term care services. PACE programs receive a monthly capitated payment from Medicare and Medicaid for eligible enrollees. PACE is intended to replicate the exemplary On Lok program in San Francisco's Chinatown. Providence ElderPlace is a PACE site in Seattle. Mental Health services are provided largely through a geriatric psychiatric nurse practitioner who conducts a bi-monthly clinic at the center. THE ARPN is also available to do home visits. This is under contract with Evergreen Mental Health. In addition, Providence ElderPlace Seattle uses Asian Counseling and Referral Services, a community mental health provider, when there are language issues. In addition, they have a contract with Community Psychiatric Clinic for substance abuse assessment and supportive services. The physician is available to monitor medications and the PACE social worker is responsible for assuring a safe placement in the community. They frequently do this through arrangement with Adult Family Homes who specialize in mental health.

1. **Primary purpose:** to manage the care of enrollees with minimal reliance on either hospitals or nursing homes.

2. **Target populations:** Medicaid clients 55 years of age and older residing in the community at the time of enrollment whose needs for long-term care are deemed to be at the nursing home level; however, Medicaid eligibility is not a requirement to enroll in the program. While not targeted specifically to adults with mental illnesses, many PACE clients have psychiatric disorders. Approximately 60 % of ElderPlace Seattle has a mental health diagnosis.

### **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** rate of hospital use, length of hospital stays
2. **Qualitative evaluation** In 1993, the Community Health Accreditation Program (CHAP) reviewed five PACE sites and found the quality and coordination of enrollee care to be exceptional

### **Evidence supporting practice:**

1. **Peer reviewed research:** PACE has been difficult to evaluate. There is some evaluation evidence suggesting that PACE resulted in reductions in hospital and nursing use while maintaining positive health outcomes and satisfaction. Kuntz and Shannon (1996) reported reduced number of hospitalizations, lengths of hospital stays, and nursing home admissions for enrolled individuals. Wieland et. al. (2000) found that hospital bed-days per 1000 PACE participants per year were comparable with the general Medicare (fee-for-service) population despite the greater morbidity and disability for PACE participants.

Gorshe, N. (1993). An effective, efficient elder care program. Providence ElderPlace focuses on maintaining the continuum of care. *Health Programming*, 74(3), 57-59.

Mui, A.C. (2001). The Program of All-Inclusive Care for the Elderly (PACE): an innovative long-term care model in the United States. *Journal of Aging and Social Policy*, 13(203), 53-67.

Rich, M.L. (1999). The PACE model: description and impressions of a capitated model of long-term care for the elderly. *Care Management Journal*, 1, 62-70.

Branch, L.G., Coulam, R.F., Zimmerman, Y.A. (1995). The PACE evaluation: initial findings. *Gerontologist*, 35(3), 349-359.

Wieland, D., Lamb, V.L., Sutton, S.R., Boland, R., Clark, M., Friedman, S., Brummel-Smith, K., Eleazer, G.P. (2000). Hospitalization in the Program of All-Inclusive Care for the Elderly (PACE): rates concomitants, and predictors. *Journal of the American Geriatric Society*, 48(11), 1373-1380.

2. **Other supporting documents:** In 1997, the Health Care Financing Administration retained Abt Associates, Inc. to evaluate PACE. They reported PACE enrollment to be associated with improved health status and quality of life, lower mortality rates, increased choice in how time is spent, and greater confidence in dealing with life's problems. To obtain PACE reports, contact Dawn Hoppe, Abt Associates, Inc., 55 Wheeler St., Cambridge, MA 02138-11568. Phone (617)520-2967.

**Practice implementation:**

1. **Staffing requirements:**
2. **Training requirements:**
3. **Cost of program:**
4. **Use of natural funding:** Pools Medicare and Medicaid dollars. In order for a state to participate in the PACE program, the State Medicaid agency must add PACE to the State Medicaid Plan as an optional benefit

**Other considerations:**

**Contact information:**

National PACE Association  
1255 Post Street, Suite 1027,  
San Francisco, CA 94109  
Phone: (415)/749-2680

**Relevant websites:**

<http://www.chausa.org/LONGTERM/LTPACE.ASP>  
<http://www.onlok.org/stats.html>  
<http://www.dhs.cahwnet.gov/director/OLTC/html/onlok.htm>

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## *Outcomes-Based Treatment Plan (OBTP)*

**Description:**

The OBTP is an integrated outcomes-based treatment planning instrument that is completed by the clinician, a patient-administered treatment outcomes questionnaire, and a set of aggregate service system quality and performance indicators. The following domains are measured:

- physical functioning
- personal care skills
- community living skills
- travel and safety
- treatment self-management

- interpersonal relationships
- leisure and community activities
- problem behaviors
- depressive symptoms
- psychotic symptoms
- negative symptoms
- substance abuse
- cognitive functioning
- general health status
- vocational
- support system risk
- residential status

Validated measures with good inter-rater and construct validity from the existing literature are used for each domain. When an older adult receives a rating on a domain, a checklist menu for treatment planning relevant to that rating is provided. A treatment planning schedule allows the clinician to document the planned treatment and the completed treatment interventions for each domain.

The extensive clinician assessment is augmented by a brief inventory of the client's health and mental health status completed by the client or the family care giver. In addition, in each of 11 domains, the patient or family care giver rates whether they perceive that the treatment has had a beneficial effect.

1. **Primary purpose:** “to assess outcomes for community-based services (excluding institutional settings such as nursing homes and hospitals) for people age .” (Grower et. al., 1994)
2. **Target populations:** Older adults with mental illness.

#### **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** improvement in practice behavior of clinicians (breadth and comprehensiveness of their assessments, range and specificity of treatments and services provided; increased measurement of progress using quantifiable anchored measures); improvement in mental health status; grater perceived benefit from mental health services by consumers.
2. **Qualitative evaluation:**

#### **Evidence supporting practice:**

1. **Peer reviewed research:** Bartels, S.J., Miles, K.M., & Dums, A.R. (2001) Improving the quality of care for older adults with mental disorders: the outcomes-based treatment planning system of the NH-Dartmouth Psychiatric Research Center. *Policy Brief of the Home Care Research Initiative, Center for Home Care Policy and Research, Visiting Nurse Service of New York: New York.*



2. **Other supporting documents:** <http://www.vnsny.org/brief11.pdf>; Bartels, S.J., Miles, K.M., Levine, K., Horn S., Sharkey, P. (199&). Improving psychiatric care of the older patient. In SD Horn (Ed.), *Clinical Practice Improvement Methodology: Effective Evaluation and Management of Health Care Delivery*, New York: Faulker and Gray, pp. 193-217.

**Practice implementation:**

1. **Staffing requirements:**
2. **Training requirements:**
3. **Cost of program:**
4. **Use of natural funding:**

**Other considerations:**

OBTP has been implemented state-wide in New Hampshire's Community Mental Health Centers and pilots are now occurring in Maine and Pennsylvania.

**Contact information:**

Stephen J. Bartels, M.D., M.S.,  
NH-Dartmouth Psychiatric Research Center  
2 Whipple Place Suite 202  
Lebanon, NH 03766  
(603)448-0126  
800-540-0126

**Relevant websites:**

[http://abstract.confex.com/ipa/11congress/techprogram/session\\_1933.htm](http://abstract.confex.com/ipa/11congress/techprogram/session_1933.htm)  
[www.vnsny.org/hcri](http://www.vnsny.org/hcri)

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## *Comprehensive Assessment Reporting Evaluation (CARE)*

**Description:**

The Comprehensive Assessment Reporting Evaluation (CARE) project is a system to enable consistent, accurate, and efficient client assessments and plans for adult Medicaid clients in need of long-term care. It is used to assess and develop service plans for clients who receive

long-term care services; to accurately measure needs and allocate resources based on medical, cognitive, behavioral and personal care needs. A staged process of implementing CARE is currently underway. Once CARE is implemented in a region, all new clients will be assessed in CARE. All existing clients will receive a CARE assessment at the time of their annual reassessment, or sooner if there is a significant change in condition.

1. **Primary purpose:** to ensure correct eligibility determinations are made for corresponding benefits; establish a standard and consistent case management process that will ensure accurate assessments and client care plans; provide a formal assessment of risk indicators to reduce liability and protect vulnerable adults.
2. **Target populations:** adult Medicaid clients in need of long-term care

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** A system for assuring quality of assessments is in place (Quality Assurance and Improvement Program, Chapter 23, Long-term Care Manual, Washington State Aging and Disabilities Services Administration).
2. **Qualitative evaluation:**

**Evidence supporting practice:**

1. **Peer reviewed research:**
2. **Other supporting documents:** Project Oversight Report, April, 2003: <http://www.wa.gov/dis/isb/041003DSHSCARE.pdf>

**Practice implementation:**

1. **Staffing requirements:**
2. **Training requirements:**
3. **Cost of program:**
4. **Use of natural funding:**

**Other considerations:**

ADSA has contracted with Deloitte Consulting for the development of the CARE system on a deliverables-based, fixed-price basis for \$2.965 million. Deloitte spent five years designing, developing, testing, and implementing a Comprehensive Assessment system for the State of Oregon. Since ADSA's business requirements match those of Oregon, the development of CARE is based upon a transfer of Oregon's design. Starling Consulting Inc. has been contracted to be conduct the external Quality Assurance.

**Contact information:**

**Relevant websites:**

<http://www.aasa.dshs.wa.gov/professional/care/>

<http://www.wa.gov/dis/isb/041003DSHSCARE.pdf>

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## *Little Havana Health Program*

**Description:**

Little Havana offers a comprehensive array of 70 services to more than 63,000 people each year through 21 multiservice community centers. The centers provide preventive social, health, nutrition, and mental health services (DHHS, 2002). The health program offers health promotion, disease prevention, health education, mental health services and primary health care. Types of settings in which health services are delivered are varied. Health care for older adults occurs in senior centers, congregate meal sites, adult day health centers, and a primary clinic. Cultural competence and sensitivity are seen as key to the success of the program. A comprehensive health and social assessment is completed for all participants in the Little Havana Health Program. The assessment includes targeted mental health questions that identify individuals for whom the program. Trained caseworkers score the assessment and identify participants at risk for depression or other mental health problems. Those identified as having a potential need for mental health services are seen by a clinical social worker. This mental health professional works with the client to develop a tailored mental health service plan, directs caseworker contacts with clients' families and follow-up referrals to the primary clinic. The primary care clinic provides counseling offered by retired professional volunteers. It also plays a key role in monitoring medications. Consultation is also provided by a volunteer psychiatrist. Some clients receive services at a nearby community mental health center.

Some clients are encouraged to participate in therapeutic activities offered at Little Havana senior centers and adult day health centers. Staff at these centers includes peer counselors trained by the clinical social worker. One of the adult day health care centers offers respite services for participants with Alzheimer's disease.

Since the many service settings cover a broad geographical area and participants need to leave home to use the services, transportation for all who need it is very important. In addition, the broad array of services must be highly integrated in order to successfully meet the needs of participants. The organizational structure and the service plan development process links the services and centers formally with the Little Havana organization. A formal linkage agreement between Little Havana and Miami Behavior Health, an outpatient mental health provider, assures that there is follow-up on referrals between the two agencies.

Informal relationships are also important. For example, the local mental health association has provided speakers for education programs and small group discussions.

1. **Primary purpose:** To meet the health and mental health needs of disadvantaged elders.
2. **Target populations:** Population at risk for isolation due to socioeconomic and language limitations.

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** Participants are observed for changes in their physical and mental status. Local Area agency on aging monitors Little Havana's services and issues reports on their performance as providers of services funded under the Older Americans Act.
2. **Qualitative evaluation:** Recognized as one of eight "exemplary" practices in the delivery of mental health services to older adults by the Western Interstate Commission for Higher Education, a national organization based in Boulder, Colorado.

**Evidence supporting practice:**

1. **Peer reviewed research:**
2. **Other supporting documents:** It was selected as one of 15 promising practices by the National Council on the Aging. These promising practices were featured in a SAMSHA report entitled, Promoting Older Adult Health.

**Practice implementation:**

1. **Staffing requirements:** on site clinical professional, retired professionals, a corps of trained volunteers, information system for tracking client assessments, service, planning, monitoring, and follow-up.
2. **Training requirements:**
3. **Cost of program:** \$8.7 million to provide services to 63,000 people each year
4. **Use of natural funding:** 70% federal government grant, 13% state grant, 6 % local grant, 11% United Way

**Other considerations:**

Retired professionals in Florida are allowed to practice without liability insurance as long as they do not charge for their services.

**Contact information:**

Ariela Rodriguez, Ph.D., L.C.S.W.  
Director, Health and Social Services  
Little Havana Activities and Nutrition Centers of Dade County, Inc.  
700 SW 8<sup>th</sup> Street.  
Miami, FL 33130  
(305)858-0887

**Relevant websites:**

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## *Kit Clark Senior Services*

**Description:**

Kit Clark is a multipurpose elder services agency providing a full spectrum of services to seniors in Boston. Thus, mental health services is one component of a program that provides nutrition programs, meals, home repair, housing programs, exercise, health education, adult day services, primary health care, and social opportunities. Kit Clark offers outpatient treatment programs for older adults with addictions or mental illness. Three clinics address these issues: 1) Geriatric Mental Health Clinic, 2) Alcohol and Substance Abuse Services for Older Adults, and 3) Gambling Treatment for Older Adults. Its addiction and mental health programs are strongly connected to senior centers where individual participants can come in for individual or group treatment sessions as well as socialize and have a meal. Referrals for mental health and addiction programs come from 35 programs offered throughout Boston by Kit Clark Senior Services. Outreach workers, direct care staff, and administrators from the network are trained to recognize substance abuse and mental health issues, discuss them with older adults, and make referrals. Kit Clark also created a network among the area agency on aging, home care corporations, clergy, hospitals and others (DHHS, 2002). Thus, referrals come from external service providers such as case managers, senior housing, managers, home health care nurses, discharge planners, and primary care physicians.

A comprehensive health and social needs assessment, the Senior Health Education and Access Assessment, is conducted. If a possible problem with addiction or mental health is indicated, a more detailed assessment occurs. A treatment plan is arrived at by the senior and a team comprised of clinical social workers, a psychiatrist, and a nurse. Besides individual and group treatment sessions at Kit Clark centers, services are also provided in home for older adults unable to come to the center.

1. **Primary purpose:** to enable older adults to maintain themselves with dignity in the community; to decrease social isolation and loneliness among seniors.
2. **Target populations:** low-income, multi-ethnic seniors.

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** concurrent medical problems are addressed; environmental stressors are addressed; whether global assessment of function improves or maintains.
2. **Qualitative evaluation:** Kit Clark has been featured in several documentaries and training videos produced by AARP and the Hazeldon Foundation, Dartmouth-Hitchcock Medical Center. It has been featured in the New York Times, Boston Herald, and Boston Globe.

**Evidence supporting practice:**

1. **Peer reviewed research:**
2. **Other supporting documents:** It was selected as one of 15 promising practices by the National Council on the Aging. These promising practices were featured in a SAMSHA report entitled, Promoting Older Adult Health.

**Practice implementation:**

1. **Staffing requirements:**
2. **Training requirements:** A curriculum has been developed entitled Passing It On, A Handbook for People Who Care About Elders.
3. **Cost of program:**
4. **Use of natural funding:** insurance reimbursement through Medicare and Medicaid; Massachusetts Department of Public Health Bureau of Substance Abuse Services, grant money.

**Other considerations:**

Only a minority of the enrollees are poor and in need of long-term care.

**Contact information:**

Georgia Neill, Kit Clark Senior Services  
1500 Dorchester Ave.  
Dorchester, MA 02122  
(607\_825-5000  
gneill@fdnh.org

**Relevant websites:**

## Over 60 Health Center

### **Description:**

This program describes itself as offering, “one-stop shopping” for a range of health-related services including health promotion, disease prevention, screening, diagnosis, and treatment for health, mental health, and substance abuse problems. It’s consumer-directed approach to mental health services is characterized by “age-specific treatment; treatment for depression that addresses loneliness and loss; inclusion of family and caregiver involvement when appropriate; treatment provided in a manner and at a pace that is comfortable for older adults; emphasis on staff training and conducting education in working with older adults; and a strong emphasis on working with other community-based services for elders.” (Promoting Healthy Aging, pp. 54-55)

Consumers are referred by community organizations and private physicians. Also, a number of health education programs that Over 60 offers in Senior Centers may draw Senior Center participants to the clinic. Primary care physicians at the center are all trained to recognize mental health problems. Informal screenings for mental health problems are a routine part of patient visits. Primary care and mental health services are provided on site. Consumers can self-refer for mental health services and primary care physicians make referrals when their mental health screening indicates mental health issues. A social work intake process occurs with each referral. The primary care physicians and the mental health clinical staff share the responsibility for treatment planning. Mental health services include assessments, individual and group counseling, medication management, and Alzheimer’s disease diagnoses.

1. **Primary purpose:** to combine primary care and mental health services so consumers do not have to travel to receive treatment.
2. **Target populations:** low income older adults

### **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** quality of life, health and functional status, knowledge, attitude, and behavior,
2. **Qualitative evaluation:** has received special recognition from the American Society on Aging

### **Evidence supporting practice:**

1. **Peer reviewed research:**
2. **Other supporting documents:** Over 60 have received special recognition from the American Society on Aging, Sisters of St. Joseph of Orange and others. It was selected as one of 15 promising practices by the National Council on the Aging. These promising practices were featured in a SAMSHA report entitled, Promoting Older Adult Health. It was selected as one of 15 promising practices by the National Council on the Aging.

These promising practices were featured in a SAMSHA report entitled, Promoting Older Adult Health.

**Practice implementation:**

1. **Staffing requirements:** physicians, nurse practitioners, physician assistants, psychiatrist, social workers, geriatric ally-trained clinical psychologists, substance abuse counselors
2. **Training requirements:**
3. **Cost of program:**
4. **Use of natural funding:** Medicare and Medicaid for social work services.

**Other considerations:**

**Contact information:**

Marty Lynch, Ph.D.  
Lifelong Medical Care  
P.O. Box 11247  
Berkeley, CA 94712-2247  
(510)704-6010  
martyl@lifelongmedical.org

**Relevant websites:**

[www.lifelongmedical.org](http://www.lifelongmedical.org)

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## *Community Contacts for the Widowed*

**Description:**

Widows were paired with a widow contact that provided emotional support and practical assistance. The program employs peers who receive training in helping their clients by establishing a one-to-one supportive relationship. These peers, called widow contacts, also arrange group sessions and conduct community education on behalf of the program.

1. **Primary purpose:** To help widows in early stages of bereavement ; to relieve stress.
2. **Target populations:** widows

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** Goldberg General Health Questionnaire .



2. **Qualitative evaluation:**

**Evidence supporting practice:**

1. **Peer reviewed research:**

Vachon, M.L., Lyall, W.A., Rogers, J., Freedman-Letofsky, K., & Freeman, S.J. (1980). A controlled study of self-help intervention for widows. *American Journal of Psychiatry*, 137, 1380-1384.

Rogers, J, Vachon, M.L., Sheldon, A., Freeman, S.J. (1980). A self-help program for widows as an independent community service. *Hospital and Community Psychiatry*, 31(12), 844-847.

2. **Other supporting documents:**

**Practice implementation:**

1. **Staffing requirements:**
2. **Training requirements:**
3. **Cost of program:**
4. **Use of natural funding:**

**Other considerations:**

**Contact information:**

**Relevant websites:**

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## *Senior Companion Program*

### **A Best Practice**

**Description:**

The Senior Companion Program is a federally funded program through Senior Corp. Senior Corp provides grants to qualified agencies and organizations for the purposes of expanding supportive services to improve the lives of older adults and their families and to enrich the lives of volunteers. There are Senior Companion Programs in every state in the nation, including Washington (Hoquiam, Pasco, Seattle, and Tacoma). In 2001, over 15,500 Senior Companions serve over 61,000 clients annually. Of those they serve, 7,150 have Alzheimer's

disease and almost 5,000 who have emotional problems ([www.seniorcorps.org/research/overview](http://www.seniorcorps.org/research/overview)).

The Senior Companion Program enlists older volunteers-peers to provide in-home supportive services and assistance with tasks of daily living to home-bound elders. Senior Companions do simple household chores, provide transportation to medical appointments, provide respite care to caregivers, and provide social support and friendship. It is expected that Senior Companions serve at least 9 months, an average of 20 hours /week. They typically serve 2-4 clients on a weekly basis. Senior Companions serve clients in a variety of settings including, an individual's home, nursing facilities, hospices, and other long-term care facilities.

1. **Primary purpose:** To enable low-income persons 60 years of age and older to remain mentally and physically active and to enhance their self-esteem through continued community participation and independent living.
2. **Target populations:** Individuals, 60 years of age and older, who may have emotional, mental health and/or physical limitations and are primarily home bound, in frail health and living alone.

#### **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** In the most recent evaluation identified, (RTI, 2003), self-reported open and closed-ended questions were developed for use in the evaluations by RTI (2003). The life domains assessed include: life satisfaction, depressive symptoms, caregiver burden, unmet need for services, health status, functional status, social functioning, and satisfaction with services.
2. **Qualitative evaluation:** Qualitative data was also collected to determine the best and worst things about the Senior Companion Program from the client's perspective and the most difficult aspects of caring for an older person, from the family member's perspective (RTI, 2001).

#### **Evidence supporting practice:**

1. **Peer reviewed research:** There are numerous peer-reviewed research articles on the Senior Companion Program (not included here). Two recent evaluations of the Senior Companion Program (RTI, 2003, 2001) were conducted to assess quality of life and quality of care outcomes for clients and families/caregivers served through the population of Senior Companion Program. Major findings include, 1) the Senior Companion program has had a positive impact on the agencies, clients and family members/caregivers served by the program, 2) Senior Companions played an important role in expanding the array of independent living services to home-bound elders, 3) Participants reported more favorable self-reported health, higher self satisfaction, fewer depressive symptoms, higher overall functioning, and fewer unmet needs at a 3 month-follow-up. Also, family members of the recipient of a Senior Companion, reported improved coping with caregiver responsibilities, fewer unmet needs with transportation, higher levels of client activity of daily functioning and satisfied with the Senior Companion. For a more comprehensive review of the findings, please see RTI, 2003.

Lee and Gray (1992) recommend that communities should adapt the program to meet their own geographic and demographic needs. They found that Senior Companion Programs in rural area are more difficult to implement due to fewer available volunteers, fewer family caregiver services and greater unmet need.

Lee, CF & Gray, LC (1992). Respite service to family caregivers by the senior companion program: An urban-rural comparison. *Journal of Applied Gerontology*, 11, 395-406.

**2. Other supporting documents:**

Research Triangle Park (RTI). (2003). Final report of the Senior Companion quality of care evaluation. Prepared for the Corporation for National and Community Service (Contract #97-743-1008).

Research Triangle Park (RTI). (2001). The role and value of Senior Companions in their communities. Prepared for the Corporation for National and Community Service (Contract #97-743-1008).

Alzheimer's Association (1991). Senior Companions, An Action Program: Alzheimer's Care Demonstration Evaluation Report. Chicago, IL: Alzheimer's Disease and Related Disorders Association, Inc.

**Practice implementation:**

- 1. Staffing requirements:** A public agency or private non-profit organization can be responsible for program operation. Program staffing will vary as a function of the size, scope and quality of the program. Senior Companion Programs are typically coordinated by a full-time or part-time program director and/or volunteer coordinator. To be eligible to become a Senior Companion, an individual must be 60 years of age and over with a limited income (150% of poverty). All applicants must undergo a background check and partake in a telephone interview.
- 2. Training requirements:** Senior Companions must complete the 40 hours of orientation, of which 20 hours must be pre-service. Four hours of monthly in-service training is also recommended. Training issues covered include, normal aging, Alzheimer's disease, diabetes, and other mental health issues.
- 3. Cost of program:** Senior Companions receive a small federal stipend for their participation (\$2.65/hour-tax free), and are reimbursed for their transportation, annual physical examination, meals, and accident and liability insurance throughout their service.
- 4. Use of natural funding:** Unknown.

**Other considerations:**

Senior Corps also administers the Foster Grandparent Program and RSVP (Retired Senior Volunteer Programs) programs. Information about program locations and program descriptions can be found on the website below.

**Contact information:**

Senior Corps Programs (Senior Companions)  
1-800-424-8867

**Relevant websites:**

[www.seniorcorps.org](http://www.seniorcorps.org)

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*In the Company of their Peers  
A Geriatric Peer Counseling Training  
Manual*

**Description:**

The Skagit Mental Health Geriatric Peer Counseling program was developed by Betty Rogers, Jere LaFollette and Wendy Rowe in 1986. The program has expanded to Whatcom, Island and San Juan Counties. The program uses trained and professionally supported seniors who work on a one-one outreach basis with older adults with mental illness, typically in their own homes (Rogers et al., 1993). Peer counselors complete training and are then matched with an older adult with mental health needs. A geriatric mental health specialist/case manager or supervisor provides support to the peer counselors through montly meetings.

The program includes, 1) community education to increase awareness of Senior Peer Counseling, 2) recruitment of peer counselors, 3) application process for peer counselors, 4) volunteer screening and the screening interview, and 5) peer counseling training and supervision.

1. **Primary purpose:** To match peer counselors with older adults with mental illness who can benefit from increased contact with a friendly visitor.
2. **Target populations:** Eligible peer volunteers are 55 years of age and older, and interested in working with older adults that have some mental health concerns. The program targets older adults with mental illness who are isolated in the community for peer counseling.

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** Unknown.
2. **Qualitative evaluation:** A descriptive evaluation was completed in 1990. Findings are included in the training manual (See below). The program was evaluated in 1990 for the previous two years (Rogers, et al., 1993). Some of the findings indicate that older adults who received the peer counseling experienced many different problems or conditions. The most commonly reported were, frequent visits to their doctors (71%), depression (69%), some type of chronic illness (64%), some degree of mental illness (61%), poor eating habits (58%) and conflict with children (36%). The typical contact between the peer counselor and recipient involved companionship, counseling, shared interests, transportation, crisis control and health monitoring to address these and other concerns. Eighty-two percent of peer counselors reported that the program had definitely benefited them personally, including feelings of usefulness, learning new and worthwhile things, and making new friends. The evaluation did not cover benefits to the recipients of the peer counseling.
3. **Monitoring:** Skagit Community Mental Health Services monitors the program through annual audits.

**Evidence supporting practice:**

1. **Peer reviewed research:** Unknown.
2. **Other supporting documents:**  
Rogers, BP, LaFollette, JG & Rowe, W. (1993). In the company of their peers: A geriatric peer counseling training manual. Mt. Vernon, WA: Nookachamps Publications, Inc.

**Practice implementation:**

1. **Staffing requirements:** Program staffing will vary as a function of the size, scope and quality of the program. Program should have a full or part-time program coordinator and support staff available to assist with program administration. A large program might also have a volunteer coordinator to assist with recruitment and training of the volunteers.
2. **Training requirements:** Peer counselors complete a training application and partake in a in-person interview. Peer volunteers complete a 50 hour, 8 week training session that is held one day/week from 9am-4pm. Training focuses on the aging process, development of listening skills, and mental health issues. Peers also meet monthly with geriatric mental health specialists for supervision and support.
3. **Cost of Program:** Unknown.
4. **Use of natural funding:** Funding comes primarily from Skagit Mental Health. Grants from the Meyer Memorial Trust.

**Other considerations:**

**Contact information:**

Betty Rogers  
Skagit Community Mental Health Services  
208 W. Kincaid St.  
Mount Vernon, WA 98273  
360-336-3193

**Relevant websites:**

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## *The Multi-faceted Primary Care Intervention*

**Description:**

This model uses the attached mental health professional approach to mental health services within primary care. It targets both younger and older adults. Those diagnosed by the primary physician as having major depression and who agreed to antidepressant therapy were given educational materials about symptoms and treatment of depression. A psychologist then provided a highly structured program in the primary setting in 4 to 6 sessions. The sessions were used to teach cognitive-behavioral skills for managing depression and to counsel on medication adherence. A psychiatrist monitored the patient's course of treatment and made appropriate adjustments to the course of treatment.

1. **Primary purpose:** to address lack of access to screening, treatment for depression and non-adherence to antidepressant medication; screen for and treat symptoms of depression,.
2. **Target populations:** adults with minor and major current depression

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** adherence to antidepressant medication, satisfaction with care of depression, depression symptom severity
2. **Qualitative evaluation:**

**Evidence supporting practice:**

1. **Peer reviewed research:**

Katon, W., Robinson, P., Von Korff, M., Lin, E., Bush, T., Ludman, E., Simon, G., Walker, E. (1996). A multifaceted intervention to improve treatment of depression in primary care. *Archives of General Psychiatry*, 53(10), 924-932.

Katon, W., Rutter, C., Ludman, E., Von Korff, M., Lin, E., Simon, G., Bush, T., Walker, E., Unützer, J. (2001). A randomized trial of relapse prevention of depression in primary care. *Arch Gen Psychiatry*. 2001;58:241-247.

**2. Other supporting documents:**

**Practice implementation:**

1. **Staffing requirements:**
2. **Training requirements:**
3. **Cost of program:**
4. **Use of natural funding:**

**Other considerations:**

**Contact information:**

Department of Psychiatry, University of Washington  
[wkaton@u.washington.edu](mailto:wkaton@u.washington.edu)

**Relevant websites:**

<http://www.shared-care.ca/katonplenary.shtml>

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## *Improving Mood: Promoting Access to Collaborative Treatment (IMPACT)*

**Description:**

This model uses the attached mental health professional approach to mental health services within primary care. Primary care patients have up to 12 months of access to a depression care manager who is supervised by a psychiatrist and primary care liaison. The care manager provides medication support and/or counseling, depression management in collaboration with the primary physician. Interventions include education, care management, support of antidepressant management by the primary care physician or brief psychotherapy for depression.

1. **Primary purpose:** to address the issue of underdiagnosis and undertreatment of mental health problems in primary care settings and in the community
2. **Target populations:** older adults with depression, dysthymic disorder, or both

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** severity of depression symptoms, depression treatments, satisfaction with care, functional impairment, quality of life.
2. **Qualitative evaluation:**

**Evidence supporting practice:**

1. **Peer reviewed research:**  
Unutzer J, Katon W, Callahan CM, Williams JW Jr, Hunkeler E, Harpole L, Hoffing M, Della Penna RD, Noel PH, Lin EH, Arean PA, Hegel MT, Tang L, Belin TR, Oishi S, Langston C. (2002). Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA*, 288(22), 2836-2835.
2. **Other supporting documents:**

**Practice implementation:**

1. **Staffing requirements:**
2. **Training requirements:**
3. **Cost of program:**
4. **Use of natural funding:**

**Other considerations:**

**Contact information:**

Center for Health Services Research,  
UCLA Neuropsychiatric Institute,  
10920 Wilshire Blvd, Suite 300,  
Los Angeles, CA 90024  
[unutzer@ucla.edu](mailto:unutzer@ucla.edu)

**Relevant websites:**

<http://www.hscenter.ucla.edu/research/impact.shtml>



# Prevention of Suicide in Primary Care Elderly – Collaborative Trial (PROSPECT).

## **Description:**

This program uses the consultation liaison approach. Health Specialists and primary care physicians collaborate in identifying depression in older adults, develop targeted and timely treatment recommendations, and encourage compliance with treatment. The intervention also includes education of patients, families, on depression and suicidal ideation. Health Specialists use a formal algorithm when selecting and prescribing anti-depressant medications to older adult patients. Psychotherapy is also used in conjunction with medication in some cases (Bruce & Pearson, 1999). This study is part of a multi-institutional effort funded by NIMH to facilitate the recognition, evaluation, and treatment of elderly patients with depression by introduction of a collaborative depression care manager into practices.

1. **Primary purpose:** to address the issue of underdiagnosis and undertreatment of mental health problems in primary care settings and in the community.
2. **Target populations:** adults with minor and major current depression

## **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** adherence to antidepressant medication, satisfaction with care of depression, depression symptom severity, prevention of suicide in these at-risk populations.
2. **Qualitative evaluation:**

## **Evidence supporting practice:**

1. **Peer reviewed research:** Reynolds, C.F. (2003). Meeting the Mental Health Needs of Older Adults in Primary Care: How Do We Get the Job Done? *Clinical Psychology: Science and Practice*, 10(1).
2. **Other supporting documents:**

## **Practice implementation:**

1. **Staffing requirements:**
2. **Training requirements:**

3. **Cost of program:**
4. **Use of natural funding:**

**Other considerations:**

**Contact information:**

[ReynoldsCF@msx.upmc.edu](mailto:ReynoldsCF@msx.upmc.edu).

**Relevant websites:**

<http://www.nimh.nih.gov/publicat/elderlydepsuicide.cfm>;

<http://www.nih.gov/news/WordonHealth/jun2000/story01.htm>

<http://www.hhs.gov/asl/testify/t030728.html>

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## *Integrated Model: Primary Care Research in Substance Abuse and Mental Health for Elders (PRISMe)*

**Description:**

The focus of the project is examination of two mental health/substance abuse models providing treatment for older adults with behavioral health problems. In one model the patient will be treated in the primary care setting using a staff integrated approach. In the other model, identified as “the referral model,” the patient will be referred to a specialty psychiatric setting. Rigorous scientific methods, including patient level randomization, will be applied to assess the effectiveness of these two models, the differences in financing of services, and the differences in utilization of MH/SA services by older consumers. There are 11 study sites, in which outcomes for older adults randomly assigned to the integrated model are compared to outcomes for those assigned to the referral model. It uses a consumer-oriented approach and emphasizes culturally competent practice interventions.

1. **Primary purpose:** to address the issue of under-diagnosis and under-treatment of mental health problems in primary care settings and in the community
2. **Target populations:** older adults with a range of mental health and substance abuse problems are participating in the study

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** engagement, participation in care, clinic outcomes, prevention, satisfaction, stigma, cultural sensitivity, provider attitudes, and cost outcomes
2. **Qualitative evaluation:**

**Evidence supporting practice:**

1. **Peer reviewed research:** Other supporting documents (e.g., reports, brochures, tool kit, training manual).
2. **Other supporting documents:**

**Practice implementation:**

1. **Staffing requirements:**
2. **Training requirements:**
3. **Cost of program:**
4. **Use of natural funding:**

**Other considerations:**

**Contact information:**

Coordinating Center: sue\_levkoff@hms.harvard.edu

**Relevant websites:**

<http://www.hms.harvard.edu/aging/mhsa/sites.htm>  
[http://www.mhaging.org/info/prisme\\_nami.html](http://www.mhaging.org/info/prisme_nami.html)

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## *Geriatric Mental Health Outreach Program*

**Description:**

This program uses the community mental health team approach. Based in a regional psychiatric hospital in Canada, this program works with informal and formal community caregivers, physicians, community agency staff, and long-term care facilities. The program

has an interprofessional consultation home visit team that conducts home and community-based assessments and completes care plans. What may distinguish this outreach programs from some others is that the team provides client-centered case consultations with health care providers who take the referrals. The Specialized Information and Resource Service gives telephone-based consultation to community care professionals as well as making referrals. The Educational Service provides resources for staff skill development of community based service providers. In addition, the program is actively involved in mental and health care system planning and coordination for older adults. It involves and develops community caregivers and local resources (Stolee et. al., 1996).

1. **Primary purpose:** to address the issue of underdiagnosis and undertreatment of mental health problems in primary care settings and in the community
2. **Target populations:** community-dwelling or institutionalized older persons with late-onset psychiatric disorders with age-related changes, and their caregivers; includes those with cognitive impairment, behavioral disturbance, physical/medical problems and depression

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** program monitoring, including a patient database and description of program activities; level of care.
2. **Qualitative evaluation:**

**Evidence supporting practice:**

1. **Peer reviewed research:** Stolee, P., Kessler, L., Le Clair, J.K. (1996). A community development and outreach program in geriatric mental health: four years' experience. *Journal of the American Geriatric Society*, 44(3), 314-320.
2. **Other supporting documents:**

**Practice implementation:**

1. **Staffing requirements:**
2. **Training requirements:**
3. **Cost of program:**
4. **Use of natural funding:**

**Other considerations:**

**Contact information:**

Renfrew County Geriatric Mental Health Outreach Program  
600 Cecelia St.

Pembroke, ON K8A 7Z3  
(613) 735-6500 or 1-877-260-0535  
Fax: (613) 735-4638  
Email: [gmh@marianhill.ca](mailto:gmh@marianhill.ca)

**Relevant websites:**

<http://www.marianhill.ca/programs/mental-health.htm>

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## *Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)*

**Description:**

PEARLS is a community-based treatment program that includes teaching problem solving techniques to relieve symptoms of depression, planning pleasant events, and increasing physical and social activities. Care managers conduct 8 one-hour sessions over 5 months. NWPEC collaborates with community based agencies that provide social support to the elderly. The client's care is coordinated between the social worker, UW researcher, and the client's physician. Participants are recruited through agency-referral and self-referral. The project was evaluated by the Health Promotion Research Center at the University of Washington in a randomized controlled study that compared outcomes for seniors receiving PEARLS versus usual care. Clients in the usual care group received regular treatment for minor depression such as medication, a referral for conventional counseling, or in many case no intervention at all.

1. **Primary purpose:** to reduce minor depression in older adults and to improve overall health and quality of life
2. **Target populations:** physically impaired, socially isolated seniors with minor depression and dysthymic disorder.

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:**
2. **Qualitative evaluation:**

**Evidence supporting practice:**

1. **Peer reviewed research:** Schwartz et. al. (2002) Case-Finding Strategies in a Community-Based Depression Treatment Program for Older Adults. *16<sup>th</sup> National Conference on Chronic Disease Prevention and Control*.

2. **Other supporting documents:** Peer reviewed journal article about to be submitted for publication: “The primary findings are that the intervention was successful at both the 6- and 12-month follow-up” (personal communication Sheryl Schwartz, 2003).

**Practice implementation:**

1. **Staffing requirements:**
2. **Training requirements:**
3. **Cost of program:**
4. **Use of natural funding:**

**Other considerations:**

**Contact information:**

Sheryl Schwartz, Research Coordinator (206)685-7258

Dick Sugiyama, Director, Case Management Program (206)684-0659

**Relevant websites:**

<http://www.cityofseattle.net/humanservices/ads/Staff-Peers/Pearls.htm>

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## *Preadmission Screening and Resident Review (PASRR)*

**Description:**

The mental health, public health, and aging network systems collaborate on the implementation of PASRR. States differ in who administers the program and how it is implemented. Some States have systems in place to use PASRR Level II screening results to develop treatment plans for mental health. Ultimately, it is the State Medicaid agency that is responsible for the PASRR program.

1. **Primary purpose:** Improve the overall quality of mental health services to nursing home residents.
2. **Target populations:** Individuals who are admitted to a nursing home that are suspected of having a mental illness are targeted for the preadmission, Level II screening.

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:**
2. **Qualitative evaluation:**

**Evidence supporting practice:**

1. **Peer reviewed research:** Snowden, M & Roy-Byrne, P (1998). Mental illness and nursing home reform: OBRA-87 ten years later. Psychiatric Services, 4, 229-233.
2. **Other supporting documents:** Bazelon Center for Mental Health Law (1996). The impact of PASARR: Report on a survey of state's implementation of the preadmission screening and annual resident review program to prevent inappropriate admission and retention of people with mental disabilities in nursing homes. Washington, DC: Judge David L. Bazelon Center for Mental Health Law.

US Department of Health and Human Services (2002). Screening for mental illness in nursing facility applications: Understanding federal requirements. (DHHS Publication No.(SMA) 01-3543). Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

**Practice implementation:**

**Staffing requirements:** Independent evaluators that have no relationship with the nursing facilities or the mental health authority conduct the Level II screening.

**Training requirements:** Professionals with expertise in mental health and aging. Knowledge of the policy and procedures of the PASARR process.

**Cost of Program:** Cost to the States vary.

**Use of natural funding:** None.

**Other considerations:**

For an excellent discussion of the requirements and regulations of PASARR please refer to, Screening for mental illness in nursing facility applications: Understanding federal requirements (DHHS, 2002). It's an easy to read source and answers the most frequently asked questions about PASARR.

**Contact information:**

State PASARR Coordinator  
Hank Balderrama  
Mental Health Division  
(360) 902-0820

**Relevant websites:**

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# The Eden Alternative™

## **Description:**

The Eden Alternative has gained a lot of attention over the past five years. The Eden Alternative ([www.edenalt.com](http://www.edenalt.com)) embraces the philosophy that “we must teach ourselves to see the environments as habitats for human beings rather than facilities for the frail and elderly. We must learn that mother nature has to teach us about the creation of vibrant, vigorous habitats”. Coalitions of individuals, organizations and agencies work together to improve nursing home environments. Ten principles guide The Eden Alternative model:

- 1) The three plagues of loneliness, helplessness and boredom account for the bulk of suffering among our Elders.
  - 2) An Elder-centered community commits to creating a Human Habitat where life revolves around close and continuing contact with plants, animals, and children. It is these relationships that provide the young and old alike with a pathway to a life worth living.
  - 3) Loving companionship is the antidote to loneliness. Elders deserve easy access to human and animal companionship.
  - 4) An elder-centered community creates opportunity to give as well as receive care. This is the antidote to helplessness.
  - 5) An elder-centered community imbues daily life with variety and spontaneity by creating an environment in which unexpected and unpredictable interactions and happenings can take place. This is antidote to boredom.
  - 6) Meaningless activity corrodes the human spirit. The opportunity to do things that we find meaningful is essential to human health.
  - 7) Medical treatment should be the servant of genuine human caring, never its master.
  - 8) An elder-centered community honors its elders by de-emphasizing top-down bureaucratic authority, seeking instead to place the maximum possible decision-making authority into the hands of the elders or into the hands of those closest to them.
  - 9) Creating an elder-centered community is a never-ending process. Human growth must never be separated from human life.
  - 10) Wise leadership is the lifeblood of any struggle against the three plagues. For it, there can be no substitute.
1. **Primary purpose:** To improve the well-being of elders and those who care for them by transforming the communities in which they live and work.
  2. **Target populations:** Residents of nursing homes.

## **Evaluating this practice:**

1. **Outcome measures used to evaluate practice:** Unknown.



2. **Qualitative evaluation:** A ten state study of nursing homes that adopted the Eden Alternative (Teitelbaum, 1995), indicate that the program improved the quality of nursing home resident's lives in terms of dignity, independence, freedom of choice, self-image, and a sense of purpose. However, in a recent study, Coleman et al., (2002) found that the Eden site had significantly greater proportions of residents that had fallen in the last 30 days, were experiencing nutritional problems, required skilled nursing and hypnotic prescriptions than the control site. The Eden site also had more new staff hired and more terminations than the control site. The researchers conclude that positive outcomes may take more than a year to observe.

### **Evidence supporting practice:**

1. **Peer reviewed research:**

Coleman, MT, Looney, S, O'Brien, J, Ziegler, C, Pastorino, CA & Turner, C (2002). The Eden Alternative: Findings after 1 year of implementation. The Journals of Gerontology, Biological Sciences and Medical Sciences, 57, M422-M427.

Hamilton, N & Tesh, AS (2002). The North Carolina Eden Coalition: Facilitating environmental transformation. Journal of Gerontological Nursing, 28, 35-40.

2. **Other supporting documents:**

Thomas, W (1994). The Eden alternative: Nature, hope and nursing homes. Sherburne, NY: Thomas.

Teitelbaum, M (1995). Evaluation of long term care survey. Unpublished report under review by the Health Care Financing Administration. Cambridge, MA: Abt Associates.

### **Practice implementation:**

1. **Staffing requirements:** Regional coordinators can provide information and training to interested nursing homes. The goal is to train the entire staff of a facility in the Eden Alternative.
2. **Training requirements:** The 3-4 day "Associate Training" as been developed over the years as a standard training program. It teaches the Ten Principles of the Eden Alternative and gives specific guidelines and suggestions for implementing them in practice. It also helps participants learn about one another to create communities of support.
3. **Cost of Program:** Unknown.
4. **Use of natural funding:** Unknown.

### **Other considerations:**

**Contact information:**

Vivian Currie, Coordinator  
Region XIII  
vcurrie@providence.org

**Relevant websites:**

[www.edenalt.com](http://www.edenalt.com)

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*Gentlecare™ Prosthetic Life Care  
System*

**Description:**

Moyra Jones is the creator of GENTLECARE. It is a paradigm of care that suggests an alternative system of care that maximizes client function for longer periods, compensates for the dysfunction caused by the disease, and protects the health of family and professional care providers” (Jones, 1999). The model is based on the belief that “appropriate care can be given only when there has been an accurate definition of the deficit a person is experiencing. Only then can the macro-environment be organized into a prosthesis of care designed to compensate for the person’s deficits, to support existing or residual function and to maximize quality of life” (Jones, 1999, p. 18). It shifts the focus of care to the physical and social environment and away from the behaviors of the individual with dementia. It involves a thorough understanding of Alzheimer’s disease and other dementia’s, assessment in dementia care, a new approach to programs, nutrition in dementia care, design for living and people and their impact on care.

GENTLECARE uses a system called POWERPOINT PROGRAMS to develop an individualized and tailored daily prosthesis of care for individuals with dementia. They programs focus on: 1) Core activities (ADL’s), 2) necessary activities (activities necessary for human health, sleep, relaxation, and privacy), 3) essential activities (those essential for human interaction and communication), and 4) meaningful activities.

GENTLECARE also focuses on changing the physical environment to meet the needs of persons with dementia. Design principles include: safety and security, access and mobility, function and activity, individual control, privacy, comfort and sociality, and flexibility, choices, change, participation, and decision making.

People as prosthesis is the third major element of GENTLECARE. The focus is on the people who are involved in the care of the individual, including family and friends, and the

individual themselves. It includes an understanding of the disease, the family caregiving process, and life stressors associated with caregiving.

1. **Primary purpose:** Utilize the macro-environment to achieve effective dementia care.
2. **Target populations:** Persons with dementia.

**Evaluating this practice:**

The program has not been formally evaluated, however, the model or model components have been replicated throughout Washington State, the US and abroad.

1. **Outcome measures used to evaluate practice:** The model monitors the following outcomes: level of functioning, participation levels in self-care activities, socialization and communication, non-cognitive and assaultive behaviors, wandering, arguments and altercations, catastrophic behavior, incontinence, family satisfaction and participation in care, volunteer and community involvement, costs of program.
2. **Qualitative evaluation:** Organizations that have adopted the model report, increased client function, reduced catastrophic incidents, decreased staff and family stress, reduced use of psychotropic medications, cost containment, increased community commitment and involvement.

**Evidence supporting practice:**

1. **Peer reviewed research:** Unknown.
2. **Other supporting documents:**  
Jones, M (1999). GENTLECARE: Changing the experience of Alzheimer's disease in a positive way. Point Roberts, WA: Hartley & Marks Publishers, Inc.

**Practice implementation:**

1. **Staffing requirements:** It is recommended that the entire staff of a facility completes the GENTLECARE training. The train-the-trainer model is also used.
2. **Training requirements:** The full training consists of 2 days/week for five weeks. Shorter training sessions or workshops are available as well. A standard curriculum has been developed using Jones' (1999) book as a guide.
3. **Cost of Program:** Unknown.
4. **Use of natural funding:** Unknown

**Other considerations:**

**Contact information:**

Moyra Jones Resources, Ltd.  
8264 Burnlake Drive  
Burnaby, British Columbia V5A 3K9  
Canada  
604-421-1680  
e-mail: jonesb@direct.ca

**Relevant websites:**

[www.Gentlecare.com](http://www.Gentlecare.com)

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## *Dementia Care Project in Boarding Homes*

**Description:**

The State of Washington Department of Social and Health Services contracts with licensed boarding homes who implement specialized dementia care services through a standard set of expectations tied to an enhanced daily rate. This comprehensive program addresses the multiple and complex needs of Medicaid clients with dementia and their caregivers. The care model is both holistic in nature and based upon meeting specific individualized needs. “The resident-centered approach is intended to promote optimum health and quality of life within an environment that accommodates cognitive deficits, maximizes functional abilities, and promotes aging in pace. Standards of care are applied uniformly across sites. They address 1) specialized dementia care assessment and service planning; 2) dementia care activities; 3) staff and staff training; 4) environment; and 5) family involvement.

1. **Primary purpose:** to deliver specialized dementia care services that promote and enhance quality of care.
2. **Target populations:** Medicaid clients with dementia.

**Evaluating this practice:**

1. **Outcome measures used to evaluate practice:**
2. **Qualitative evaluation:**

**Evidence supporting practice:**

1. **Peer reviewed research:**

## *Resource Guide*

### 2. Other supporting documents:

#### **Practice implementation:**

1. Staffing requirements:
2. Training requirements:
3. Cost of program:
4. Use of natural funding:

#### **Other considerations:**

#### **Contact information:**

#### **Relevant websites:**

<http://www.aasa.dshs.wa.gov/professional/documents/DementiaStandards.doc>