Promoting Older Adult Health

Aging Network Partnerships to Address Medication, Alcohol, and Mental Health Problems
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Acknowledgments

Numerous people contributed to the publication of this guide. Alixe McNeill, Assistant Vice President for Program Development at the National Council on the Aging, Inc. (NCOA), and Mary Brugger Murphy, Senior Advisor to NCOA, served as the lead researchers and authors. Project direction was provided by Jennifer Fiedelholtz, Government Project Officer, SAMHSA. Expert advice and guidance was provided by Eileen Elias (SAMHSA), Jennifer Solomon (SAMHSA), Nancy Whitelaw (NCOA), Melanie Starns (Administration on Aging), David Turner (NCOA Health Promotion Institute), Ron Schoeffler (NCOA National Institute of Senior Centers), Willard Mays (National Coalition on Mental Health and Aging), and Frederic Blow, Ph.D. (University of Michigan).

Thanks are also extended to the national organizations that assisted in the identification of promising practices, the individuals who made the effort to describe and nominate programs, and all the individuals from the nominated programs who provided the information needed for review of the nominations.

The volume would not have been possible without the energy and patience of the contact persons for the 15 programs profiled in this guide. They spent considerable time describing their programs, responding to many questions, and reviewing and revising the descriptions. Their willingness to serve as a resource to the readers of this guide is most appreciated.

This guide was prepared by the National Council on the Aging, Inc. (NCOA), for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS), under purchase order #99M00632601D, Jennifer Fiedelholtz, Government Project Officer. The content of this publication does not necessarily reflect the views or policies of SAMHSA or HHS, nor does it necessarily reflect the views of NCOA.

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At the dawn of a new millennium, we take stock of where we have been and where we may be going. Not surprisingly, as we move into the 21st century, this Nation can anticipate dramatic changes. One of the most significant is the demographics of the American people. By 2030, people over the age of 65 are expected to account for 20 percent of the population, up from 13 percent today. The effect is already being felt in social and health care support systems at the local, State, and Federal levels. We cannot wait for tomorrow to address these changes.

Perhaps nowhere is the need for attention more evident than in the areas of substance abuse prevention, addiction treatment, and mental health services. Relatively few people are focused on or aware of the significance of alcohol, medication, and mental health-related problems among older adults. Yet as many as 17 percent of older adults are affected by alcohol and/or prescription drug misuse, and an estimated 20 percent of older adults experience mental disorders that are not a normal part of aging. These problems affect not only the length of life but also the quality of life.

The good news is that these problems are preventable and treatable. They are perhaps even more responsive to treatment than other chronic illnesses, such as heart disease and diabetes. The bad news is that, like other populations across the age spectrum, older adults are often reluctant to seek assistance from the substance abuse and mental health service delivery systems.

To help bridge the gap between older adults and the mental health and substance abuse services they may need, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Council on the Aging, Inc. (NCOA), sought the advice of service providers and older consumers. We learned that substance abuse and mental health service providers are working successfully with aging services organizations in a number of communities to meet the needs of older people, providing models that can be adopted and adapted in locations across the country.

This publication is designed to help older adults gain access to needed substance abuse and mental health services by promoting new linkages between well-known, trusted, and heavily utilized providers of aging services and relevant substance abuse and mental health services. By joining these systems, we can more successfully identify older adults who are at risk for problems with alcohol, medication, and mental disorders and connect them with the prevention, education, outreach, and treatment services that can dramatically improve their lives.

SAMHSA and NCOA are proud to have partnered in the development of this publication. Our partnership, and the State and local partnerships identified in this publication, can serve as models for our colleagues around the country. The result of this collaboration will be measured in the improved quality of life for countless millions of older Americans, both today and for decades to come.

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Two frequently overlooked health problems among older adults are the often inadvertent misuse and abuse of alcohol and medications, including both over-the-counter and prescription medications. Mental health problems, such as depression and anxiety disorders, also are frequently overlooked among adults over the age of 65 but can have a significant impact on their health. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Council on the Aging (NCOA) have joined together to confront and help respond to these issues by creating this guide for community-based organizations helping at-risk seniors.

In 1999 and early 2000, SAMHSA and NCOA convened a series of meetings with service providers and older consumers to gather their input regarding priorities for action related to alcohol and medication misuse/abuse and mental health problems of older adults. Both groups articulated a need for greater understanding of these problems among older adults as well as strategies for addressing them. SAMHSA and NCOA were specifically asked to provide concrete, practical guidance on how mental health, substance abuse, primary care and aging services providers can collaborate to provide education, prevention, screening, and referrals to treatment for seniors who may be experiencing or at risk for these problems.

Older adults often are reluctant to seek services from traditional substance abuse and mental health providers for a variety of reasons, including the stigma associated with these issues. Organizations providing social, health or supportive services for older adults, including primary care providers, are uniquely positioned to play a vital role in linking elders at risk for alcohol or medication misuse/abuse or mental health problems to the full continuum of service: education, prevention, screening, and treatment.

The Aging Services Network—57 State agencies, 655 area agencies, and more than 27,000 seniors centers, adult day services, nutrition programs and other service providers—is a tremendous resource to help address substance misuse and mental health problems among American seniors. Each year, this network serves approximately seven million of the 35 million older adults in this country. Many of those seniors may be having problems with alcohol or medications, or may be experiencing mental health

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1 The aging process varies from individual to individual. For this reason, no one term can be used to describe all people as they grow older. This volume uses the terms “older adult,” “elder,” and “senior” interchangeably. These terms are not intended to imply diminished capacity or loss of independence. Rather, they describe people experiencing the normal aging process.
problems. The organizations in the Aging Services Network can play a critical role in education, identification, screening and referral to other services.

Primary care providers are in an outstanding position to reach older adults with or at risk for mental health problems as well as for alcohol or medication misuse or abuse. Education, screening, and preventive interventions easily can be provided during regular visits with a primary care provider. Many older people prefer to receive treatment for mental health or substance abuse problems in primary care settings, although some people will require the more specialized services offered by mental health and substance abuse service providers.

Partnerships between organizations providing social, health and supportive services (“aging services providers”) for seniors, mental health providers and substance abuse providers have significant potential to enhance the availability and accessibility of the full continuum of services needed by older adults with or at risk for mental health problems or problems with alcohol and medication misuse or abuse. SAMHSA and NCOA have developed this guide to facilitate collaborations among mental health, substance abuse, and aging services providers. The guide:

- identifies programs across the country that are linking with community partners to provide seniors with needed support without requiring individual organizations to commit large amounts of staff time or money;
- highlights how these programs operate and offers lessons from their successes; and
- shows how a direct approach to addressing substance abuse and mental health problems among older adults can enhance the capabilities of aging services and foster vital aging in older adults.

The guide is grounded in a belief that experience is the best teacher. While inclusion in this volume does not imply a formal endorsement of a program by SAMHSA or NCOA, it is hoped that the information provided will be of assistance to others in developing and implementing programs to address the alcohol and medication misuse/abuse and mental health needs of older adults.

The profiles in this guide offer a broad range of models to address substance abuse and mental health problems in older adults. Some partnerships involve formalized contractual arrangements between multiple organizations. Others are based on informal working relationships. Regardless of the approach that has been taken, these organizations have learned many important lessons about how to initiate and maintain partnerships with others on behalf of the older adults that they serve. It is worth noting that many of the service providers profiled in this guide had no previous experience in helping older adults with alcohol, medication and mental health problems. They developed the ability to counter these problems by building community alliances.

Alcohol, Medication, and Mental Health Problems Among Older Adults

The good news is that substance abuse and mental health problems are highly treatable and often preventable. Research has shown that older adults who engage in risky drinking (e.g., drinking beyond recommended limits or while taking certain medications), but who are not
dependent on alcohol, can reduce alcohol use and related problems through relatively simple, brief interventions. Older adults with more significant alcohol problems (i.e., alcohol dependence) also respond well to treatment, completing treatment at higher rates than do younger adults (SAMHSA 1998). The efficacy of treatment for mental health problems is well documented, and a range of effective treatments exists for most mental disorders (DHHS 1999, Chapter 5). Nonetheless, older adults often need assistance to identify and respond to these problems. The promising practices profiled in this guide work because aging services providers are well positioned to reach older people in need of help. These providers have time-honored relationships with their clients that allow them to discuss difficult issues, offer hope, and provide support as their clients face mental health problems or problems related to medication and alcohol misuse or abuse. This guide offers a window on innovative approaches to address these problems by promoting partnerships between aging services organizations, that have the access to older adults, and the substance abuse and mental health organizations that have the expertise in addressing substance abuse and mental health problems.

Health and social services providers often do not recognize the warning signs of substance abuse and mental health problems. They may attribute the symptoms of a substance abuse or mental health problem among older adults to the natural course of aging. They also may avoid the topic because of the stigma associated with substance abuse and mental illness. In some cases, providers may believe that they’re not capable of helping, or they may believe that treatment doesn’t work—that it’s not even worth trying. As a result, seniors in need of assistance may never receive adequate care, even though treatment is effective and has tremendous potential to improve the health and quality of life of many older adults.

**Alcohol Problems**

As people grow older, their bodies are less able to handle alcohol safely. Alcohol-related problems (including interactions with prescription and over-the-counter drugs) account for most of the known substance-related problems experienced by older adults. Estimated community prevalence rates range from three to 25 percent for “heavy alcohol use” and two to 10 percent for “alcohol abuse” (SAMHSA 1998).

The National Institute on Alcohol Abuse and Alcoholism (NIAAA), part of the National Institutes of Health, offers recommendations for low-risk drinking. According to NIAAA, seniors who do not drink should not start; those who take medications for sleeping, pain, or anxiety also should abstain from alcohol. For other individuals over the age of 65, NIAAA recommends no more than one drink per day (NIAAA 1998).

Recommended drinking limits are lower for people over 65 because changes in the aging body—a decrease in water content, lower tolerance to alcohol, and decreased ability to metabolize alcohol—can make even small amounts of drinking risky. Given these physiological changes, alcohol use can trigger or exacerbate serious problems among older adults, including increased risk for hypertension, heart problems, and stroke; impaired immune system and capacity to combat infection and cancer; liver disease; decreased bone density; gastrointestinal bleeding; depression, anxiety, and other mental health
problems; malnutrition; and sleep disturbances (SAMHSA 2000).

Senior centers and other providers of services for older adults often are in contact with people with late-onset problems related to alcohol abuse. Prevention and education programs profiled in this guide have successfully reached out to people with or at risk for late-onset problems, a group that is highly receptive to education efforts. Some senior centers collaborate with Alcoholics Anonymous and other peer support groups to help older people who are in recovery. Elders with early-onset problems who continue to abuse medications or alcohol may be isolated and may be reached by trained intervention teams. Many times, these people already have been in contact with substance abuse and mental health service providers.

Medication Problems
As people age, they consume more prescribed and over-the-counter medications. Persons over the age of 65 consume more medications than any other age group in the United States. Thirty percent of these individuals take eight or more prescription drugs daily and consume other over-the-counter drugs. A large share of prescriptions for older adults are for psychoactive, mood-changing drugs that carry the potential for misuse, abuse or dependency.

About one fourth of all people over age 65 report use of a psychoactive drug in the past year, and they appear to be more likely to continue use of these drugs for longer periods of time than younger individuals (SAMHSA 1998).

Older adults account for more than half of all reported adverse drug reactions that lead to hospitalization. The sheer volume of medicines taken by older individuals creates an increased risk for drug interactions, including interactions with alcohol and other medications. Physiological changes that accompany aging can render drugs harmful even at low levels of consumption (SAMHSA 1998).

Medication misuse occurs when a person uses medication at an unsuitable dose; when medication is used for contraindicated purposes; when a drug is used in combination with other medications with undesirable interactions; when a person skips doses; and when medications are used with alcohol. Most older adults do not intend to misuse medications or alcohol. However, even when misuse is inadvertent, it can result in decreased functional and cognitive capacity, placing an older person at greater risk for falling, hospitalization or placement in a nursing home (Roy and Griffen 1990). Attention, memory, physiological arousal, and psychomotor abilities often are impaired; drug-related delirium or dementia may be wrongly labeled as Alzheimer’s disease (SAMHSA 2000).

A variety of risk factors influence the use and potential for misuse or abuse of psychoactive prescription drugs and over-the-counter medications by older adults. The aging process with its physiological changes, accumulating physical health problems, and other psychosocial stressors make prescription drug use both more likely and more risky. The most consistently documented correlates of psychoactive prescription drug use are old age, poor physical health, and female gender. Among older women, use of psychoactive drugs is correlated with middle- and late-

\[^{2}\] Problems that people develop at early ages are called “early-onset” and those that develop in later life are called “late-onset.”
life divorce, widowhood, less education, poorer health, higher stress, lower income, and more depression and anxiety. Major losses of economic and social supports, as well as previous or co-existing drug, alcohol or mental health problems also seem to increase vulnerability for misusing or abusing prescribed medications (SAMHSA 2000).

**Mental Health Problems**

Mental disorders also affect many older adults. The first Surgeon General’s Report on Mental Health, issued in 1999, stated that almost 20 percent of people over the age of 55 experience mental disorders that are not part of “normal aging.” The most prevalent mental disorders among older adults include anxiety disorders, which affect an estimated 11.4 percent of people over age 55. Severe cognitive impairment affects 6.6 percent of the population over age 65. Mood disorders, including major depression and other forms of depression, affect about 4.4 percent of people in this age group. Unrecognized or untreated, these disorders can cause severe impairment and can even be fatal. Suicide frequently is a consequence of depression. Older adults—particularly older white men—have the highest suicide rate in the United States. White men over age 65 have a suicide rate up to six times that of the general population (DHHS 1999).

Among primary health professionals, there is often the misperception that symptoms of mental disorders (e.g., feeling depressed) are merely a normal aspect of aging, or that clinically significant depression is “just a grief reaction” to the losses of aging rather than a genuine problem requiring clinical help. Health and social services providers may believe the problem is not worth treating in older adults, or simply find it too difficult to address this issue (DHHS 1999).

At the same time, the Surgeon General’s report noted that the majority of older adults are able to cope constructively with the limitations and losses of later life. The report also observed that mental health and health care providers increasingly are able to suggest successful strategies for older adults who are striving to make this stage of life satisfying and rewarding (DHHS 1999).

**Creating This Guide**

To develop this guide, SAMHSA and NCOA asked service providers across the country to identify local or State programs that were addressing medication, alcohol, and mental health problems among seniors in effective and unique ways. Nominations were solicited from NCOA members and constituent units; from Federal health agencies; from national organizations in the aging, mental health, and substance abuse fields; from the National Coalition on Mental Health and Aging; and from the public via the Internet.

Over 40 responses were received. With input from leaders in the field, the list was narrowed to the 15 promising practices profiled here. The result is a broad and varied selection of excellent programs. All of the submissions were insightful, and many of those not selected for inclusion in this guide are identified in Appendix 1 for reference. Criteria used to select the programs included:

- Reliance on community linkages and effective collaboration among involved aging services organizations and substance abuse or mental health services providers;
• Use of convenient service location(s);
• Successful outreach;
• Emphasis on cultural competence;
• Use of a strong client-centered approach;
• Increased service capacity over time; and
• Use of few or carefully defined resources.

Each program was asked to provide some evidence of success, ideally through program evaluation or documented analysis of successful outcomes. Few programs were able to meet this standard. However, each of the programs profiled has been able to provide information about achievements, recognition by external organizations, or other descriptors of success.

Each program is distinctive and unique. Some programs take a holistic approach to prevention and treatment, addressing medication misuse and mental health as an integral component of their overall programming. Other programs are more specialized. Some reach out aggressively and directly to older adults in need of service, while others concentrate on assisting specialists to reach seniors with substance abuse or mental health problems.

Extensive efforts were made to include a comprehensive array of programs and service populations. However, not every type of program sought was found. For example, a program that targeted Native American elders with mental health or medication and alcohol-related problems was not found. However, a very useful issue paper on serving Native American elders developed by the National Indian Council on Aging is available. Organizations interested in starting such a program are encouraged to contact the National Indian Council on Aging. Contact information for this organization and other national groups offering assistance to this endeavor is provided in Appendix 2.

How to Use This Guide

This guide provides information on how several different programs work, how they got started, and the resources needed for operation. Program Directors have offered ideas and initial direction to those interested in developing or expanding services. Their insights are designed to help other providers add these components to already established health programs. The guide further allows service providers to browse and search for particular components of individual programs. One aspect of a program might be suitable, while others may not.

The guide is organized into sections according to the steps that service providers use to respond to substance misuse and mental health needs:

• Education and Prevention
• Outreach
• Screening, Referral, Intervention, and Treatment
• Service Improvement Through Coalitions and Teams

Profiles in each section outline exemplary activities related to the section topic. Each profile includes a description of the program (including an overview of the specific promising practice, as well as a discussion of outreach and recruitment, services, and client monitoring and assessment), linkages with other organizations, evidence of success (including program assessment and external recognition), resources and funding, and lessons learned about how to get a similar program started.
Contact information is included for each program. Program representatives are enthusiastic about sharing their information with others in the field. They want to see their programs used to help their colleagues.

The guide is not designed to create a new role or treatment capability for aging services providers. Rather, it is a resource. It offers pathways, through community linkages, to help organizations serving older adults provide education, make effective referrals, and create connections to needed services in order to improve the lives of older adults.

Lessons Learned

In reviewing the promising practices in this guide, a number of themes or “lessons learned” can be identified. They are outlined below. The main lesson learned is that community linkages are essential to successful practices. By building partnerships with other health, academic, and government resources, service providers are able to improve the lives of the older adults they serve. These linkages also position organizations serving older adults as an attractive and vital resource in the community.

The role of organizations providing services targeted to older adults—as opposed to the role of substance abuse and mental health organizations—is defined by the programs in these profiles. At some points in the service continuum, such as education, screening and referral to services, these organizations are intimately involved in the process. At other points, such as assessment, diagnosis, and treatment, these aging services organizations play a more peripheral role. Regardless of the point at which they enter the service continuum, several specific characteristics define successful programs.

Persistence

Essential to all programs is the need for persistence on the part of the staff. Whether service providers regularly visit the home of a client whose neighbors think they detect a problem or return to a client with follow-up questions on a particular issue, persistence pays off.

Consumer-Friendly Services

The most common statement made by individuals interviewed for these profiles is that older adults with medication and alcohol-related problems or with mental health problems are unlikely to self-refer. One way to counteract their reluctance is to make services available in a setting in which older adults are comfortable, such as a senior center they are already attending, or in the setting in which they regularly receive other health care, such as a primary care clinic.

Cultural Competence

Cultural competence is a recurring theme in these promising practices. It covers a broad range of issues, from treating older adults with respect to speaking the language and dialect of individual clients and understanding their heritage. Staff at successful programs take into account the diversity of their clients.

Multi-Service Programming

One effective approach is to make these services part of a larger, comprehensive service program. For example, one Program Director described how a client recovering from depression was encouraged first to
join a group, then to add another group, then to add lunch, then to take on a class—all under the same roof. Another program made household repairs to decrease falls in the home. After building trust with the clients, providers were able to address other reasons for falls, such as medication and alcohol-related problems.

**Health Promotion**
Most of the providers discuss these health-related issues within the context of sessions on general well-being or living with challenges of aging. A long-term approach that builds trust and sends persistent messages over time empowers older adults to seek help for substance abuse and mental health problems.

**Comprehensive Assessment and Consumer Direction**
Another approach to substance abuse and mental health problems is to include these topics in the assessment process and to address them in the manner—and at the time—most appropriate for staff and client. In most client-centered programs, for example, the individual may spend months on changing eating habits and other responses to stress in order to build up the strength to tackle something as difficult as a drinking problem. When they do take it on, it is their decision and they are ready to change.

**Peer Support, Staffing, and Evaluation**
These programs mobilize a variety of staff to meet each community’s needs. Peer volunteers—members of the same age group—can speak to seniors on common ground. Other programs use interdisciplinary teams, often a social worker and nurse working in tandem. In some cases, staff members reach out to older adults in their own homes. Promising practices put emphasis on the importance of staff selection, as well as training, evaluation, and outcomes assessment.

**Collaboration at All Levels**
Models of collaboration show how State-level activities can be complemented by local initiatives. In one case, three different States support programs in a single metropolitan area. Another program for older adults engages up to 40 different agencies and providers to offer a therapeutic approach that encompasses all the needs of each individual client.

**Cross-Training**
Community linkages also encourage cross-training. Substance abuse and mental health providers need training to understand how to work with older adults; likewise, aging services providers need training to identify mental and behavioral health issues. One promising practice cross-trains aging services providers, mental health counselors, and alcohol and medication misuse professionals, creating a network that is linked in three places.

**University Links**
Most promising practices include a link to at least one university. By participating in research projects, programs can examine and document their work. One program with three distinct components undertook these components only after conducting studies to determine their effectiveness. Another approach to university linkage involves placement of students in aging services centers, thereby enhancing staff capacity.
Resources

Many programs profiled in this guide use materials that may be helpful to other aging services, mental health, or substance abuse providers as they initiate programs and services for older adults. Where possible, these materials are identified in the program profiles.

Three key publications focused on aging, mental health and substance-related issues are available from the Federal government and may also be of assistance:

- **Mental Health: A Report of the Surgeon General** takes a lifespan approach in considering mental health and mental illness, examining how age, gender and culture influence the diagnosis, course and treatment of mental illness. The report highlights the fact that a range of effective, well-documented treatments exists for most mental disorders. The report also proposes broad courses of action to improve the quality of mental health in the nation. It is available on the Internet at www.surgeongeneral.gov. Copies may be purchased from the Superintendent of Documents at the Government Printing Office. The Executive Summary is available free of charge by calling 1-877-9-MHEALTH.

- **Older Adults and Mental Health: Issues and Opportunities** is a companion document to **Mental Health: A Report of the Surgeon General**. A major emphasis of the report is on the delivery of mental health and supportive services to older Americans. It describes community mental health services, mental health services in primary and long-term care, and Medicare and Medicaid financing of mental health services. Supportive services discussed in the report include respite care, adult day services, support groups and peer counseling programs, wellness and health promotion programs, mental health outreach services, and caregiver programs. It is available on the Internet at www.aoa.gov/mh/report2001. A limited number of copies are available from the National Aging Information Center at 202/619-0724.

- **Substance Abuse and Older Adults: Treatment Improvement Protocol #26** aims to advance the understanding of the relationships between aging and substance abuse and to provide practical recommendations for incorporating that understanding into practice. The report covers identification, screening and assessment, as well as treatment and outcomes for adults age 60 and over. The volume is part of a series of best practice guides produced for health care and substance abuse treatment providers. It is available on the Internet at www.samhsa.gov. Printed copies may be obtained by calling the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686. Companion publications targeted specifically to social service providers, primary care providers, and physicians have been developed, as well, and are available from NCADI.

In addition, several Federal agencies and national organizations provide a wide array of resources (including consumer education materials, publications, data, and technical assistance materials) that may be of assistance to organizations seeking to enhance their ability to address mental health and substance-related problems among older adults. Appendix 3 includes a listing of select Federal agencies and...
Several States and communities across the country have established coalitions of mental health, aging, primary care and substance abuse organizations. These coalitions, listed in Appendix 4, are an additional resource for organizations interested in expanding services for older adults. They have been successful in such areas as development of educational materials on the mental health needs of older adults, provision of cross-training activities, and identification and resolution of systems barriers to substance abuse and mental health services by older adults.

References


Introduction

Education programs equip older adults with information vital to understanding substance misuse/abuse and mental health problems. Prevention measures are efforts to intervene either to prevent a problem from occurring in the first place, or to reduce the severity and consequences of a problem once it has occurred. Education and prevention are integral components of all programs that address medication, alcohol, and mental health problems in older adults. These health promotion, wellness, and self-efficacy programs offer an opportunity for aging services professionals to provide tips to older adults on recognizing and addressing medication and alcohol-related problems and mental health issues.

The later years of life may bring stresses that can lead to increased risk for medication and alcohol-related problems. The loss of spouses, friends, and other loved ones; changing social roles; increased isolation; and decreased physical capacity and illness present many challenges to older adults who may need help coping with these difficulties. Education and prevention programs focused on building coping skills can help prevent problems when these losses occur. Programs also need to convey details about the dangers of substance misuse and abuse (Michigan Older Adult Substance Abuse Network Web Site, 2001).

Older adults coping with new physical limitations, cognitive changes, and various losses often are susceptible to mental disorders. Unrecognized or untreated, disorders such as depression, anxiety, and schizophrenia can be severely impairing, even fatal. There is growing awareness of the value of prevention in the older adult population. Primary prevention programs are aimed at preventing problems such as depression or suicide from occurring by targeting interventions to high risk older adults. Treatment-related prevention programs aim to prevent relapse or recurrence of underlying mental disorders. Other prevention efforts target avoidance of excessive disability, encouraging older adults to maximize function. Another important goal of prevention programs is to avoid premature and unnecessary institutionalization (Michigan Older Adult Substance Abuse Web Site, 2001).
In addition to providing basic information, effective prevention programs must address the attitudes, values, relationships, environmental factors, and social relationships that characterize the lives of older adults. Further, prevention needs to focus not only on deterring self-destructive or harmful behaviors, but also on promoting health and wellness (Michigan Older Adult Substance Abuse Network).

Common elements of successful education and prevention programs include:

- outreach to seniors in settings where they are most comfortable;
- the establishment of peer support systems;
- the use of age-appropriate materials;
- a commitment to healthy aging;
- family and care provider involvement;
- principles of adult learning (rather than didactic teaching);
- an active role for the older adult;
- the involvement of an expert or the use of recognized resources;
- primary strategies that focus on the improvement of health habits;
- health screening, including checks for poor nutrition and medication side effects;
- targeted (or secondary) prevention that focuses on groups at risk, so as to promote positive behavior; and
- systems-focused approaches that take into consideration the complex array of service needs of most older adults (Michigan Older Adult Substance Abuse Network).

Promising Practices in Education and Prevention

The promising practices featured in this section were found in a network of senior centers and nutrition sites in Miami/Dade County, FL, and in groups of senior centers and public housing facilities in Salt Lake County, UT, and Seattle/King County, WA.

These programs share several elements. They encourage older adults to take an active role in their own health and well-being; they show a commitment to supporting the individual in his or her quest for good health and services; and they integrate mental health and medication and alcohol-related problems into overall health promotion programming.

The programs urge providers to seize the opportunity to identify problems by including medication- and alcohol-related problems and mental health issues in routine health screening, health education and other health promotion activities. By casting the net broadly, problems that might otherwise go undetected are identified. Staff members try to present educational information in a positive context. As one director said, “If we schedule a session on depression, no one will come. But if we have a session on ‘Making the Most of Your Life,’ many will join—and we can talk about depression as an obstacle to overcome.”
Implications for the Aging Network

Education and prevention practices can be added easily to most aging services programs without placing undue burden on staff or financial resources. These services can be offered in senior centers, senior housing sites, and sites offering congregate meals. By addressing these issues through education and prevention—ideally by linking with programs that address medication and alcohol-related problems and mental health resources in the community—service providers acknowledge the presence of these problems and encourage older people to adopt healthy lifestyles. In the end, seniors in need of treatment are connected to appropriate providers.

Resources

Aging services programs interested in developing education and prevention efforts that include mental health and substance abuse issues are encouraged to contact service providers in their communities to discuss the potential for collaboration. In addition to providing needed services for clients who may be at risk for or experiencing problems with medication or alcohol misuse or abuse, staff at substance abuse or mental health organizations may be available to assist with educational workshops, provide informational materials or provide other types of assistance. Several Federal agencies and national organizations provide consumer information, publications, data and other materials that may be useful in developing education and prevention activities. A list of these Federal agencies and national organizations is provided in Appendix 3.

References

Promising Practice:
Healthy Aging Program, Salt Lake County, UT

Healthy Aging Program at senior centers and senior housing incorporates substance abuse education, prevention, screening, referral, and continuing support.

Contact:
Carolyn Scharffenberg, Program Manager
Salt Lake County Aging Program
2001 South State, #S-1500
Salt Lake City, UT 84190-2300
Phone: 801/468-2473
Fax: 801/468-2769
email: cscharffenberg@co.slc.ut.us
web site: www.slcoagingservices.org/healthy.htm

Sponsoring Organization
Salt Lake County Aging Program, an area agency on aging, sponsors the Healthy Aging Program.

Demographics
The program serves a large population of older persons in Salt Lake County. The county has one of the highest percentages of individuals age 85 and older in the Nation, and it projects extremely high numbers for 2020 and beyond. While the area’s long-term population is primarily Scandinavian, there are also significant numbers of recent immigrants from Russia, Bosnia, Vietnam, and elsewhere.

Recognition
The program has received three achievement awards from the National Association of Counties.

About the Promising Practice
The Healthy Aging Program is based on the principles of education and empowerment of the older adult. It integrates substance abuse and alcohol education and prevention, screening, and referral into its overall programs of disease prevention services, dynamic health promotion and education, clinical screening and referral to treatment and follow-up support. Through the program, medication and alcohol-related prevention strategies are used to help older adults understand and successfully cope with the physiological and social changes they may be experiencing without resorting to drugs or alcohol. The Healthy Aging Program provides services to 17 county-administered senior centers and 29 senior housing centers. In calendar year 1999 (through November) the program had 18,575 client encounters.

How It Works
The Healthy Aging Program serves older adults who attend senior centers, live in senior housing, or are referred to the program by other community based organizations that serve older adults. It encourages participants to recognize unhealthy behaviors and to adopt healthier lifestyles.
It offers prevention education, counseling, and support, as well as referral to treatment and follow-up support.

Program participants also attend weekly classes, facilitated by health educators, that address lifestyle factors such as diet, stress management, exercise, and medication. The program offers English language and life skills programs for elders who immigrated late in life to help them avoid the problems that can result from isolation.

Outreach and Recruitment
Older people are referred to the program and its substance abuse screening by senior housing managers, senior center staff, and others who work with older persons. Healthy Aging Program staff and volunteers also reach out to elders by offering health screening and health education sessions throughout the county.

Services
Project Lift, the program’s substance abuse assessment and referral service, offers comprehensive assessments to older people referred to the program. A licensed counselor conducts the assessment, which includes the Michigan Alcohol Screening Test–Geriatric Version (MAST-G). (See Appendix 5 for details on MAST-G.) Individuals identified as experiencing the early stages of medication and alcohol-related problems are served directly by the Healthy Aging Program. If the initial assessment indicates that a person has a significant problem with substance dependence, the appropriate referral to an appropriate substance abuse treatment program is made.

After treatment, the Healthy Aging Program stays in contact and encourages individuals to participate in follow-up activities that provide support in adjusting to a new lifestyle. Staff foster involvement in exercise classes, health education classes, and senior center activities to help prevent relapse. The program works informally with each participant to set goals to prevent relapse.

Primary prevention and relapse prevention efforts use group education, individual counseling, and group counseling. These services foster increased coping skills and encourage adoption of healthy lifestyles. Education offers information on the benefits of eliminating misuse and abuse of alcohol, medications, and other substances.

Participants are mentored by peers and staff on increasing self-awareness and self-efficacy. Elders are encouraged to participate in other program activities, establish healthy relationships with peers and others, and contribute to their community through volunteer service. A bimonthly support group is available.

These prevention services are integrated with other components of the Healthy Aging Program, including:

- broad health education and promotion
- a brown bag medication review and seminar
- the Senior Scholar program, aimed at enhancing mental acuity
- English as a second language, including practical life skills for recent immigrants

Health education programs include physical health issues and mental health topics such as Mind Your Meds; Coping with Stress; Vitamins and Herbal Treat-
ments; Alzheimer’s and Parkinson’s; Humor; Dog Days of Summer; Good Grief; and A New Light on Depression. Seniors help select topics through surveys and focus groups. Among the resources used for the educational programs are the health promotion materials distributed by the National Council on the Aging and its Consumer Information Network. Health education material also is distributed monthly to Meals-on-Wheels clients.

Brown bag medication reviews are coordinated with senior pharmacy students from the University of Utah. Participants bring their prescription and over-the-counter medications, vitamins, and herbal treatments to the seminar for a discussion of side-effects, cautions, and concerns.

**Monitoring and Reassessment**
The Healthy Aging Program works with clients who have problems with both alcohol and medications, including herbal medications (not an insignificant issue in this geographic region). Alcohol abuse prevention support is offered when clients are observed to be under stress and vulnerable. Case management, health education, and exercise are offered as alternatives to alcohol use. As part of the pharmacy program, medications and herbal supplements are reviewed in terms of needs and use. Chronic disease management is covered, because this is another area that can lead to substance misuse.

The Healthy Aging Program also conducts pre- and post-tests as part of its education series; a nurse assesses physiological status; a health educator tests for health knowledge.

**Linkages**
The Healthy Aging Program educates professionals who work with the senior population about substance abuse and the elderly. In carrying out this mission, staff present extensively at gerontology conferences, aging programs, the Salvation Army, hospitals, provider networks, and housing and home health agencies.

Healthy Aging services are coordinated through formal agreements with the University of Utah (student placements), the Valley Mental Health Masters Program (seniors with depression), and Salt Lake County Substance Abuse Prevention/Treatment and other health care providers. Informal agreements with local housing authorities and private housing organizations are utilized to provide housing-related services, and additional students placements are arranged informally with a variety of educational programs.

Many referrals, both formal and informal, are made to local practitioners, providers of other aging services, and to the services offered by the county Office on Aging. Some people with alcohol use problems are referred to the Salvation Army and to treatment programs. In addition, referrals are made to the Community Service Council for resources such as a food bank and services such as home maintenance.

**Program Assessment**
The agency is working to improve its program evaluation measures. Collaboration with the clinical section has strengthened evaluation of the health interventions. The next step is to assess the program’s impact on visits to the emergency room and physicians. The agency is designing a study and seeking support to assess education as a
method of changing health habits among older adults with chronic health problems who use medications and alcohol.

**Resources and Funding**
The program uses about 400 volunteers each year, including students. Many are drawn from nearby schools of nursing and social work. Students are attracted by the opportunity to work with older adults seeking an independent, healthy, and dynamic lifestyle. Older volunteers, including retired nurses, lead many of the educational sessions. Critically important is the health educator, with alcohol and substance abuse credentials, for screening and individual counseling.

Current funders of the program’s nearly $400,000 annual budget include Salt Lake County Substance Abuse, Salt Lake County government, the Utah State Division of Education, and the Federal Older Americans Act. (Contact the program for additional information on its resources and funding.)

**Getting Started in Salt Lake County**
The Healthy Aging Program, with its mental health and substance abuse components, was created in 1983, when the founding director sought county funds for educational programs for seniors—programs based on the premise that if seniors felt better about themselves and their personal strengths, they would handle the losses of later life in a manner more compatible with good health. The initial $30,000 grant covered the cost of a lunchtime education program in the 12 senior centers in the county and in housing units.

As the educational program evolved and expanded over the years, so did the clinical program. Several health screens were added to the health education programs. With the growth of the program came increased professionalism, more technology, a higher grade of health educators, and greater ability to tap into the community and schools, including inter-generational programming.

**Getting Started in Other Communities**
This program could be replicated in most senior centers with an interest in integrating substance abuse prevention services with health promotion. The program manager recommends involvement with colleges and universities and notes the importance of a trained health educator with a background in substance abuse.

Materials available from the Healthy Aging Program include consumer health education brochures (one for Project Lift includes warning signs and information on substance abuse), clinical protocols, information handouts, and testing results sheets. Monthly calendars list classes and resources and offer health education on a selected topic.

**Keys to Success**
According to the program staff, the most significant key is the intentional education and empowerment of the older adult client. Cultural competence also is critical. The Salt Lake County program serves not only the primarily Scandinavian long-term population, but also the growing numbers of older adults who have emigrated from Russia, Bosnia, Vietnam, and elsewhere.
Promising Practice:

Health Enhancement Program, Seattle/King County, WA

Health Enhancement Program, operating at senior centers and public housing sites, helps seniors identify goals for their own health, adopt healthy behaviors, and avoid behaviors that are not healthy, including substance abuse.

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Sponsoring Organization
Senior Services of Seattle/King County is Washington State’s largest not-for-profit agency serving seniors. It offers an array of services to seniors in the Seattle/King County area, including information and assistance, a senior wellness program, senior rights assistance, nine senior centers, six adult day health centers, numerous congregate meal sites and home-delivered meals, volunteer transportation, homesharing, minor home repair, and African American outreach.

Demographics
Senior Services serves Seattle/King County. The Northshore Senior Center, which initiated the promising practice, the Health Enhancement Program, serves a primarily Caucasian community. Other centers serve Asian and African American populations. The materials for these programs are being adapted for different cultures and translated into other languages.

Recognition
Articles about randomized controlled studies documenting the program’s success in reducing hospital stays and emergency room and doctor visits have appeared in the Journal of Gerontology, the Journal of Gerontological Nursing, and the Journal of the American Geriatrics Society (see References below). Results also have been reported extensively in the popular press.

About the Promising Practice
The Health Enhancement Program helps older people recognize health improvement opportunities, adopt healthy behaviors, and minimize behaviors that are not healthy. The program is highly client-centered and client-driven. It is one of three complementary programs that make up the Senior Wellness Program. The others address exercise and chronic disease self-management.
How It Works

The Health Enhancement Program is a proven intervention to prevent functional limitations and reduce unnecessary or inappropriate health care use.

Outreach and Recruitment

The Health Enhancement Program operates in 20 service sites frequented primarily by seniors, including the North Shore Senior Center and four other sites. Participants begin by completing a detailed self-evaluation of health status, attitudes, and behaviors. They choose the issues they are ready to work on, using a readiness-to-change model. In 1999, 700 elders and 80 peer mentors participated.

Services

After completing the self-evaluation, participants undergo a comprehensive health and social assessment which helps them identify health improvement opportunities that they can pursue by modifying their personal behavior. A nurse offers feedback on areas of concern as well as strengths, and helps participants design personal health action plans. For each area of concern, participants have short-term goals and become managers of their own programs for behavioral change. They rate their own health initially and at 6 months and 12 months.

They also work with a social worker and may choose to work with a health mentor. The health mentor is a trained peer volunteer who has been a participant in the program. Most of the program’s social workers have advanced degrees in social work. All are trained by the clinical supervisor, a nurse.

Frequently, in the course of striving to meet one goal—improved physical fitness, for example—participants may “discover” that other factors, such as tobacco, alcohol abuse, or mental health problems, are interfering with their efforts. Through this process of self-realization, individuals often become much more motivated to work on the underlying problem with the assistance of their mentor and program staff.

Most mental health concerns are identified and addressed through counseling and self-management programs offered at the sites. Referrals are made, as needed, to mental health and substance abuse programs in the community.

A Health Enhancement Program social worker provides individual and group counseling, offers support groups, and conducts classes on topics that are identified in the groups. She has found that offering these programs in community centers rather than in a medical setting helps reduce the stigma surrounding mental illness and substance abuse issues that often prevents individuals from seeking assistance. If an individual is referred to an outside provider of mental health or substance abuse services, staff maintain contact, as they would with any other provider.

The program offers support groups for social activation, depression, anxiety, and memory problems. It identifies treatment possibilities and provides outlines for group sessions.

Many of the participants also benefit from a Chronic Disease Self-Management Program offered at the sites. Originally designed by Kate Lorig, Ph.D., and associates at the Stanford University Patient Education Center, the program has
achieved documented improvement in healthful behaviors and health status, and a decrease in days of hospitalization. The findings of the original randomized study were corroborated in test results for enrollees at the Seattle Northshore Center. Three hundred older adults took part in this program in 1999.

For those whose individual goals call for improving physical fitness, the Lifetime Fitness exercise program offers low-cost, 1-hour supervised classes for ongoing 5-week sessions of three classes per week. Components include strength training, aerobics, balance, and stretching. The program was piloted and tested, and has been found to produce marked improvements in physical and social functioning as well as in the relief of pain, fatigue, and depression.

**Monitoring and Reassessment**
Participants are monitored on an ongoing basis by program staff and volunteer mentors. They meet at least every 6 months with their nurse or social worker to evaluate their progress and to reassess goals for the next 6-month period. In addition, their health action plan is sent to their primary care physician, who has an opportunity to make recommendations.

During this process, participants may identify new goals to meet or behaviors to modify. Their health action plans are adjusted accordingly. This process is aided by comprehensive client-tracking software.

**Program Assessment**
The Health Enhancement Program measures outcomes by tabulating participants’ reports of the number of days of hospital care, bed rest, and restricted activity; the number of emergency room and doctor visits; progress on specific issues; and health status. A randomized, controlled study using the health enhancement intervention found a reduction of 38 percent in the number of seniors hospitalized; a reduction of 72 percent in the number of hospital days; a reduction of 36 percent in the use of psychotropic medications; significantly higher levels of physical activity; and improved functioning in activities of daily living. In another study, peer mentors active in the program themselves reported significant improvement in frequency of exercise, range of social activities, and ability to manage chronic conditions.

Senior Wellness and its Lifetime Fitness Program have been evaluated rigorously as senior center-based disability prevention programs. One hundred adults were recruited for a randomized, 6-month clinical trial, during which all members of the experimental group received exercise intervention, nutrition counseling, and a home safety assessment. Smoking and alcohol interventions were delivered to at-risk subjects. Eighty-five percent of intervention subjects completed the 6-month program. Adherence was excellent. After 6 months, the intervention group scored significantly better than the control group on seven of eight subscales of the Medical Outcomes Study Short Form (SF-36). The SF-36 measures such outcomes as physical functioning, role limitations due to physical health, role limitations due to emotional problems, bodily pain, mental health status, energy, and fatigue. The intervention group also displayed fewer depressive symptoms as measured by the Center for Epidemiologic Studies Depression Scale (CES-D).
**Linkages**
Primary linkages include the client’s primary care physician, psychiatrist, or case manager through formal agreements between Senior Services and participating health systems. These linkages are used with the client’s concurrence to enhance care. There are also formal linkages with the health department, the housing authority, and the area agency on aging in the form of contracts and funding agreements.

As the success of the ongoing programs demonstrates, partnerships are key. For example, very few senior centers have a nurse on-site. The Health Enhancement Program has nurses in 20 senior centers, through support from the county health department, area hospitals, health care systems, city government, a private foundation, and other organizations. Linkages have also been established with the Group Health Cooperative, Stanford University, and managed care organizations. The University of Washington has funded evaluations of the program. The high level of support from health care systems is a direct result of the program’s success in reducing hospitalization and its linkage to primary care physicians.

**Resources and Funding**
When the study phase of the Health Enhancement Program was completed, the first source of outside funding was the area agency on aging. This agency continues to support the programs, as do the health care organizations, hospitals, and health departments.

Other resources include the University of Washington’s Northwest Prevention Effectiveness Center (funded by the Federal Centers for Disease Control and Prevention), which provides a geriatrician to evaluate the program annually. Nurses are provided by participating health service networks. The program receives grants from private foundations and other support from the county department of health. The senior centers in which the programs operate provide such resources as space, equipment, and staff time for training and operations.

The program can provide additional information on its resources and funding.

**Getting Started in Seattle/King County**
The Health Enhancement Program has its roots in the Senior Wellness Project, initiated by the Northshore Senior Center to test Lifetime Fitness, the exercise program described above. Senior Wellness was a collaborative project with the University of Washington and the Center for Health Studies at Group Health Cooperative. Compared with controls, participants had greater improvements in measures of physical function. Depressive symptoms also significantly improved. Replication began in other centers in 1995.

Building on the success of the Lifetime Fitness program, the Northshore Center developed the Health Enhancement Program in collaboration with several partners, including three health systems—Group Health Cooperative, PacificCare, and Evergreen Health Care.

**Getting Started in Other Communities**
In addition to expanding to 20 sites in the Seattle/King County area, the program has expanded to 10 sites in nearby counties, as well as to two sites in the State of Virginia.
Training, technical assistance, and materials are available to foster successful replication. Materials include the licenses to use the extensive computer programs to track individual client progress. Susan Snyder at Senior Services is knowledgeable about contractual arrangements, opportunities, and fees. Her advice on funding for those interested in starting such a program is to contact health care providers, get to know them, and develop partnerships with them that will be mutually beneficial.

**Keys to Success**
The Senior Wellness Project demonstrates how local aging services agencies can use evidence-based public health strategies to improve the health status and functioning of their clients.

Some administrative factors in the program’s success include:

- use of controlled studies as programs are initiated
- significant partnerships with universities and the health care community
- the ability to link programs and resources within one organization

Key program factors include:

- participant-centered approach
- range of program offerings
- careful approach to staffing (which requires a part-time to full-time nurse and social worker whose belief systems allow them to work comfortably alongside trained peer volunteers)
- emphasis on social interaction
- use of trained volunteers to enhance health promotion in a cost-effective manner

**References**


Promising Practice:

Little Havana Health Program, Miami/Dade County, FL

Nutrition and senior centers serving Hispanic elders offer tailored mental health services to meet specific needs identified through comprehensive assessment.

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Fax: 305/854-2226

Sponsoring Organization
Little Havana is one of the Nation’s largest multipurpose nonprofit agencies, serving disadvantaged elders and younger families. It 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 to a population that is at risk for isolation due to socioeconomic and language limitations—isolation that can lead to physical and mental deterioration.

Little Havana’s health program includes health promotion, screening, assessment, disease prevention, health education, mental health services (including counseling), and primary health care. Group meals, nutrition, physical fitness, home injury control, and transportation services round out the program. Health services are delivered through the agency’s activity and nutrition centers, including senior centers, congregate meal sites, four adult day health care centers, a primary care clinic, a mobile medical unit, an employment agency, and two intergenerational preschool child care centers.

Demographics
Miami and metropolitan Dade County are urban areas with a large population of adults age 60 and over and the highest concentration of Cuban Americans in the United States. Most of the elderly client base emigrated to the United States as mature adults. The median age is 79. Many live alone, in substandard housing, with incomes of about $530 a month.

Recognition
Little Havana was recognized as one of eight “exemplary” practices by the Western Interstate Commission for Higher Education, a national organization based in Boulder, CO.
About the Promising Practice
Little Havana offers mental health services tailored to meet the specific needs of elderly participants. These needs are identified through a comprehensive health and social assessment. The assessment, which includes targeted mental health questions, is conducted with participants in the Agency’s nutrition program, senior centers, and other service programs. More than 700 elders received mental health outreach and services in 1999.

How It Works

Outreach and Recruitment
Program participants are contacted or recruited through community outreach for isolated elders, through the meal program, and through all other services of Little Havana.

Comprehensive Assessment and Service Plan
All program participants are required to undergo a comprehensive health and social assessment with assistance from a trained caseworker. The Little Havana clinic’s primary care physician, volunteer psychiatrist, and other volunteer professionals work with participants to develop tailored plans of services, based on the findings of the initial assessment and professional evaluation. All services are integrated internally so that clients, through the caseworkers, have access to all they might need, if it is available in the community.

Intake and assessment forms ask for information about the individual’s background, finances, monthly expenses, medical insurance, health status, medications, health habits (including alcohol and tobacco), ability to perform activities of daily living (ADLs), and instrumental activities of daily living (IADLs). The assessment includes an orientation screen on time and place, the Center for Epidemiological Studies’ 11-item depression screen, a nutrition screen, and a social history.

Trained caseworkers score the assessment and identify participants at risk for depression or other mental health problems. Participants identified with potential mental health problems are referred to the supervising mental health professional, a clinical social worker who directs caseworker contacts with clients’ families as well as follow-up referrals to the primary care clinic. These professionals advise clients on services or treatment needed to address their conditions.

When an assessment indicates that a serious mental disorder requiring immediate treatment may exist, staff asks the client’s permission to contact the client’s family or physician. When possible, assessment findings are shared with the physician so that treatment can begin or a referral can be made. Some clients are encouraged to seek help from a nearby community mental health center. Little Havana’s primary mental health services are tailored to older people with a variety of mental health problems. For those receiving outside treatment services, Little Havana’s services support their treatment with an array of nutrition and social support services.

Services
Participants whose assessments indicate symptoms of depression are counseled by Little Havana clinical staff and by
retired professional volunteers. At-risk participants also are offered consultation and treatment with the program’s volunteer psychiatrist. When isolation or loss is found to be a major factor, clients are encouraged to participate in therapeutic activities offered by Little Havana senior centers and adult day health centers conducted, in part, by peer counselors trained by the clinical social worker. Participants also may be encouraged to serve in a volunteer role to increase opportunities to establish or enhance social support systems.

Medication misuse is considered a major problem for the population served by this program. Countering such practices and educating on proper medication use is a key activity of the medical staff, as are medication reviews and counseling.

When symptoms of Alzheimer’s disease are present, participants are encouraged to take part in the Little Havana demonstration site of the Hispanic Alzheimer’s Disease Initiative, a national demonstration begun in 1992 that offers center- or home-based respite services. Center-based respite services are offered in one of the four adult day health care centers. Transportation is offered to all who participate in the adult day health care centers.

**Monitoring and Reassessment**

All those attending a senior center, adult day health center, or other program are observed for changes in their physical or mental status. Reassessment and referrals are made as needed.

**Linkages**

Little Havana has developed both external and internal linkages in building its extensive capacity to address the mental health needs of disadvantaged elders. Little Havana receives funding and referrals through its formal contractual linkage with the local area agency on aging, Alliance for Aging, Inc. The network of aging services providers in the two-county area also provide referrals.

Little Havana works extensively with Miami Behavioral Health, a provider of outpatient mental health services, referring participants for services through a formal linkage agreement. Informal linkages with the mental health association have resulted in speakers for education programs, periodic “charlas” or “little talks,” and mental health educational presentations at the senior centers.

Internally, all of Little Havana’s services and centers are linked formally through the organizational structure and the service plan development process. Little Havana also formally collaborates with sponsors of community employment programs, serves as a training site for senior employment service workers, and hires many of those who complete the training.

**Program Assessment**

Little Havana health and social services programs offer timely interventions for people beginning to show signs of mental problems. The services provided, along with peer support and the opportunity to discuss concerns in an accepting environment, assist many participants in averting avoidable deterioration.
The local area agency on aging—the Alliance for the Aging, Inc. (AAI)—monitors Little Havana's services and issues reports on their performance as providers of services funded under the Older Americans Act. Consumer satisfaction is monitored and included in these performance reports. The executive director of the AAI has indicated that the monitoring reports on Little Havana are consistently outstanding.

**Resources and Funding**

The total agency budget of $8.7 million is funded primarily through government grants (Federal 70 percent, State 13 percent, and local 6 percent). The remaining 11 percent is funded by United Way, participant contributions, private donations, and fundraising efforts. The costs of outreach, screening, assessment, referral, and mental health services are not separated out.

One unusual source of funding flows from the State Office of Children and Families but originates with the Federal Office of Refugee Resettlement. This is the first time such funding has been used for elderly refugees. Other organizations serving refugees are encouraged to assess the availability of these funds by contacting the Federal office or the State unit handling these concerns.

The agency staff numbers 193. Of the total, 116 are age 60 or over, and more than 60 percent work part-time. In addition, there are 517 volunteers.

Florida State law extends “sovereign immunity” to retired professionals, which allows them to practice without liability insurance as long as they do not charge for their services. This means that older physicians, including a volunteer psychiatrist, can (and do) work in the clinic. In addition, some services are provided by professionals who bill Medicare directly, the only Medicare reimbursement for services at Little Havana.

The program can provide additional information on its resources and funding.

**Getting Started in Miami/Dade County**

Little Havana has been in operation since 1972. The comprehensive assessment and treatment program began in 1992, when a strategic decision was made to hire a licensed clinical social worker, Dr. Ariela Rodriguez, to direct the agency’s health and social services unit. Through her efforts, the comprehensive assessment procedures were established. She and staff worked with the National Institute of Mental Health to develop an appropriate assessment form, with screens for mental health and dementia. Over time, the comprehensive assessment form was modified, but the mental health screen was retained.

The only resistance to the addition of the mental health components in 1992 came from staff who felt that the comprehensive intake form was too detailed and included too many personal questions. As staff expertise has grown, staff have come to value and rely on the information collected in the assessment process.
Getting Started in Other Communities

According to Dr. Rodriguez, any organization can offer tailored mental health services. The resources needed include a clinical professional on-site, retired professionals, a corps of trained volunteers, and an information system to track client assessments, service planning, monitoring, and follow-up.

Descriptive program material is available through Little Havana. The organization also makes available its comprehensive intake and assessment form, including the mental health screens. This form is bilingual in Spanish and English.

Keys to Success

• Cultural competence and sensitivity
• Transportation for all who need it
• A comprehensive assessment for all clients
• An integrated array of services

Cultural competence is the heart of this program. Competence involves more than speaking the same language as the clients. There must be sensitivity to the clients’ culture, the clients’ origins, and, in the Little Havana area, the refugee or immigrant experience. An important consideration in the Cuban culture is the tradition of accepting anything said or done by an elder. Many younger staff members prefer to ignore inappropriate behavior rather than address it as a possible symptom of dementia and risk offending an elder. Modifying this mindset is critical if these problems are to be acknowledged and addressed. Knowing the culture intimately allows the Little Havana staff to pick up cues that might otherwise be missed. For example, Cuban elders traditionally dress meticulously when attending the center, much as they would dress for church. Any sharp change in an individual’s appearance thus alerts the staff to be concerned about possible mental health deterioration in that individual.
Introduction

Outreach is an effort to identify older adults in need of mental health or substance abuse services and to help them get the care they need. Aging services providers can play an instrumental role in these efforts by reaching out to older adults with serious problems who are not likely to seek formal services on their own. They may deny that they have a problem, be too ill to recognize their need, or avoid seeking substance abuse or mental health services because of the stigma attached to such problems.

It often falls to others to notice signs of problems and point the way to appropriate services. “Others” in this case may include the staff and trained volunteers of a senior center, a senior residence, or an area agency on aging. Often, it can include those who interact with older adults in crisis: adult protective service workers, police officers, and housing inspectors. It also can include members of the community at large: public and private employees whose work, though unrelated to senior services, brings them into regular contact with older adults—mail carriers, repair persons, power company employees, bank tellers, and others.

While outreach programs are designed to help older adults, these programs can be extremely beneficial to aging services organizations as well. By receiving the services and support they need, clients of aging services providers are often able to remain in their homes and maintain their independence.

Promising Practices in Outreach

Reaching older adults sometimes requires an innovative outreach approach. Two of the promising practices outlined in this section train public and private workers who are in frequent contact with isolated older adults to observe potential signs of trouble. When a problem arises, the observers can make a single telephone call to alert personnel prepared to serve older adults in crisis. These so-called “gatekeeper” programs offer a tested strategy to mobilize public and private sector workers to build community outreach. These individuals are not expected to screen, assess, or even interview. They simply pass on their observations. The key is to have a well-coordinated response system and an adequate service structure in place when calls come in.

One of the practices outlined here involves an intervention team that follows up on calls from gatekeepers. The second trains public housing employees to act as gatekeepers; they, in turn, contact trained...
nurses and psychiatrists, who respond with in-home assessment and services. The third program in this section uses an interdisciplinary team to provide in-home crisis intervention to stabilize older adults through linkages with community services. The team is composed of a nurse, a psychiatrist, and geriatric mental health specialists.

Just as outreach is essential to reach older adults with substance abuse or mental health needs, persistence is crucial to connect these individuals with services. These promising practices offer prime examples of the need to “meet people where they are.” According to Raymond Raschko, developer of the gatekeeper concept, there are two general rules about seniors in need: The more at risk they are, the less likely they are to recognize the problem and ask for help; the more at risk they are, the less likely they are to get help unless someone else intervenes on their behalf.

**Implications for the Aging Network**

The gatekeeper concept is relatively easy for aging services programs to implement because of its simplicity, the limited role of community partners, and the extensive materials already available. This type of initiative requires little added staff time or money. At the same time, it requires little from the gatekeepers; they are asked only to be vigilant and to make one phone call if they discover a potential problem. The role of the aging services network is to work with substance abuse and mental health service providers to have the appropriate services and systems in place to react to referring calls. This type of outreach offers substantial benefits. It helps clients stay in their own homes and improves their self-care. If the community does not have such a program, it may be desirable to start one. Successful implementation requires broad commitment throughout the community. If a gatekeeper-type program does not exist in a community, aging services providers can work with local mental health and substance abuse agencies to get one started.

**Resources**

The training materials for Gatekeepers are particularly useful in starting an outreach program. They include:


Aging services organizations that are interested in developing outreach efforts targeted to older adults at risk for alcohol, medication or mental health problems are strongly encouraged to work with local substance abuse and mental health agencies in this endeavor. The availability of appropriate assessment and intervention services is crucial to the success of any outreach effort. Local substance abuse and mental health programs can provide these needed services. The area agency on aging often can be of assistance in identifying appropriate substance abuse or mental health providers. Local mental health and aging coalitions are another good starting point. Appendix 4 provides a listing of State and local mental health and aging coalitions known to SAMHSA at the time of publication. In the absence of a State or local coalition, service providers can work with State or local colleagues to convene such a group. Materials developed by the AARP Foundation on building aging, mental health, substance abuse, and primary care coalitions are available from the American Psychological Association, Office on Aging (202/336-6046).
Promising Practice:
Gatekeeper, Spokane, WA

Public service personnel and local businesses collaborate with an integrated mental health and aging agency to train workers who are in daily contact with elders to observe signs of serious problems and place a call for help.

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Sponsoring Organization
The parent organization of the original Gatekeeper program was the Elder Services Program of the Spokane Community Mental Health Center. Information and resources for the model are now found at the Washington Institute for Mental Illness Research and Training, sponsored by Washington State University and the Washington State Mental Health Division.

Demographics
Spokane County is 80 percent urban/suburban and 20 percent rural. The population is primarily Caucasian. Minorities comprise 5 percent of the population age 60 and older.

Recognition
In 1992 the Kennedy School of Government at Harvard University, in conjunction with the Ford Foundation, selected Elder Services from among 1,600 applicant organizations to receive one of ten national $100,000 awards as an Innovative Program in State and local government. In 1999, the mental health program of the Western Interstate Commission for Higher Education received funds from SAMHSA’s Center for Mental Health Services for an exemplary practices identification project. The center identified Gatekeeper’s case-finding model as one of eight “exemplary practices in the delivery of mental health outreach services to older adults.” Gatekeeper has received other awards from the National Council on the Aging and the American Psychiatric Association. The work of the program and evaluation findings are reported in professional articles published in Journal of Case Management, The Gerontologist, Hospital and Community Psychiatry, and The Annals of Pharmacotherapy. These articles are listed below under References.
About the Promising Practice

Gatekeeper is a community-wide system of proactive case-finding to identify high-risk older adults. The model was developed in 1978 by Raymond Raschko, director of Elder Services for Spokane Mental Health. The target population of the Gatekeeper case-finding practice is community-dwelling adults over age 60 who are experiencing any or all of the following:

- serious and persistent mental illness
- emotional or behavioral problems
- poor physical health
- individual living situation (i.e., living alone)
- absence of a support system
- abuse or neglect
- substance abuse
- reluctance or inability to seek help

How It Works

Gatekeepers are nontraditional referral sources who are organized and trained to identify high-risk older adults living in the community. They are employees of corporations, businesses, and community organizations who come into contact with older adults through their everyday work. They include postal service workers, meter readers, police and sheriff department personnel, bank tellers, cable television installers, pharmacists, resident apartment managers, property appraisers, code enforcement workers, emergency medical response teams, ambulance company personnel, humane societies, and many others.

Outreach and Recruitment

With training, using the extensive materials developed over the years, gatekeepers learn how to become keen observers of an older person’s appearance, mental and emotional state, personality changes, physical changes and losses, social problems, and potential substance abuse; conditions of the home; caregiver stress; financial hardship; and risk for suicide. Gatekeepers are trained to call the community agency designated to accept referrals when they encounter an older adult who appears to need assistance. The source of the referral is kept confidential to protect that individual’s relationship with the older person.

Services

After initial referral, a multidisciplinary team conducts a comprehensive assessment that includes physical, mental, emotional, social, and support system components. The primary care physician is contacted as well. Once the assessment is complete and service needs are determined (with input from the older person), a service plan is developed in collaboration with members of the team and staff from existing community supports, including appropriate community service agencies. Not all gatekeeper referrals require a comprehensive assessment and service plan. For some, simple linkage to a community-based service, such as chore services, is all that is needed. Gatekeeper program staff inform the gatekeeper who made the initial referral that contact was made with the older adult. However, to protect the older adult’s right to privacy, the specific life circumstances and service plan remain confidential.

Elder Services, which operates the Gatekeeper program, provides ongoing clinical case management. This consists primarily of a clinical case manager who has access to a team leader, a psychiatrist, and a phar-
macist to make home visits for evaluation as well as for treatment and services. Services such as home health, personal care, respite, Meals-on-Wheels, and support groups are brokered and coordinated by the clinical case manager.

Program staff members do encounter isolated individuals who refuse contact and services. In many cases, staff work to build rapport and trust, engaging in concrete activities that result in positive outcomes. Persistence and outreach frequently lead to acceptance and subsequent treatment and services.

Because gatekeepers are trained only as observers, not as clinicians, the development of an integrated and coordinated mental health, aging, and social service system is essential to program success, as are a relevant multidisciplinary response system, crisis response, and coordinated in-home services.

**Monitoring and Reassessment**
The clinical case manager maintains close contact through ongoing home visits and has primary responsibility for counseling, treatment and service plan coordination, and monitoring and reassessment. Contact is maintained with all agencies providing services as well as with the primary care physician.

**Program Assessment**
Researchers (from Washington State University and the University of Washington) studied the population reached by Gatekeepers. They analyzed older people referred to the Elderly Services Division of Spokane Mental Health by Gatekeepers as well as traditional referral sources, including medical/health agencies, family, friends, social services agencies and other sources. Findings indicate that clients referred by gatekeepers were more frequently socially isolated, economically disadvantaged, more likely to live alone and less likely to have physical health problems. They were also less likely to have a physician, though this differential did not exist after one year in the program. At the time of referral, those referred by gatekeepers had greater service needs; after one year, they did not use more services than those referred by other sources. Conclusions drawn from evaluation research are that the Gatekeeper model is inexpensive to implement and can benefit communities through increased collaboration among service providers. It was also reported that adoption of the Gatekeeper model does not result in high service utilization. A second published process evaluation of the demonstration project involving 10 rural sites in the State of Washington may be of special interest to organizations considering replication. Copies can be obtained from Dr. Jensen, who is the program contact for the Gatekeeper program. Funding for the project came from SAMHSA’s Center for Mental Health Services Community Action Grant program. Dr. Jensen will soon be completing a second process evaluation, which will be entitled “Gatekeeper Model of Case Finding At-Risk Older Adults: Implementation in Ten Rural Sites in Washington State.”

Quality of life outcomes have been considered and are addressed in some of the articles listed below that have been published since the program began. According to program founder, Raymond Raschko, outcomes related to knowledge, attitude, and behavior have not been considered in the articles because the population served is at such high risk. They have noted evidence of improved attitudes and behavior on the part of caregivers. Service-related outcomes also have been considered and noted in the articles.
Linkages
In Spokane, Elder Services, the lead agency, has formal agreements with 16 community agencies to provide the coordinated system of care. These agencies include:
- mental health agencies
- the area agency on aging
- home and community services
- adult protective services
- substance abuse agencies
- crisis services
- adult day health
- home health agencies

Formal and informal linkages with local businesses and public services support the recruitment, training, and work of the gatekeepers.

Community ownership of the model is critical since the model affects all systems. Program developers recommend that communities wanting to replicate the model create formal mental health and aging coalitions to work together to meet the specific needs of their community.

Resources and Funding
At the individual level, gatekeepers are told that their involvement will not cost them anything but their time. They simply do what they normally do—but with heightened sensitivity. If they observe a potential problem, all they have to do is make a phone call to report their concerns.

At the community level, cooperating businesses and agencies provide resources in the form of staff time for training. Agencies and organizations involved in referral and service delivery also must commit sufficient resources to maintain an effective response system. In addition, staff time is necessary to take on the community-wide organizing activities needed to get the system up and running. It is possible to start with one-quarter of an employee. However, it is likely that a full-time position eventually will be needed. Another consideration is the cost of providing training and training materials.

Funding for the Gatekeeper program in Spokane comes from the area agency on aging through both Older American Act and Washington State Senior Citizens Services Act funds. Other funds come from the Spokane Regional Support Network, the regional mental health authority.

The program can provide additional information on resources and funding.

Getting Started in Spokane
The Gatekeeper model was created in 1978 in Spokane in response to the inadequate level of mental health services provided to older adults. It was developed to address fundamental reasons for the problem: that neither the aging nor the mental health systems provided the necessary off-site outreach needed to bring older adults into care. Gatekeeper was designed to approach the older adults directly and draw them into the system. It has continued to operate in Spokane since its initiation.
Getting Started in Other Communities

The Gatekeeper program has been replicated in many sites. In 1996, the model was adapted in Pierce County, WA, and renamed HEROS (Helping Elders through Referral and Outreach Services) to emphasize its uniqueness in that community and promote its ownership there. In 1997 and 1999, grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) made it possible to introduce the model to an additional ten counties in the State. Other known sites of replication can be found in Arizona, Florida, Maryland, Michigan, Oklahoma, Oregon, Pennsylvania, Wisconsin, Wyoming, and British Columbia.

Successful replication relies on an adequate and responsive service system in which aging and mental health services have been linked. Before recruitment and training begin, communities must have formalized referral and service response systems in place. A single point of entry for incoming referrals must be identified and agreed upon by the community.

Gatekeeper recruitment may vary from one community to the next. It is important to target corporations, businesses, and community organizations whose workforces have the greatest opportunities for interacting with older adults. Cold calls, face-to-face contacts, letters, and public media announcements all have been used to introduce the concept to potential Gatekeepers. Training sessions typically are held at the workplace, last up to one hour, and are flexible to accommodate work schedules and time demands of the workforce. Retraining also is scheduled periodically.

Materials, including a training manual and video, are available to assist in the replication. These materials are listed in the references below. Program staff can provide information on how to obtain these materials.

Other descriptive videos include:

- HEROS (Helping Elders through Referral and Outreach Services), Pierce County, Washington. Gatekeeper Replication Program.
- “Gatekeeper Program/Old Friends.” Produced by the Washington State Bureau of Aging and Adult Services, 1988, 15 minutes.

Keys to Success

Raymond Raschko, the program founder, cited the keys to Gatekeeper’s success as the integration of major systems; the targeting of an at-risk population; the use of both traditional and nontraditional approaches to identify clients; the use of crisis intervention; the use of interdisciplinary teams; the integration of funding streams; and the development of screening and triage protocols. Obviously, successful gatekeepers must represent, or at least understand and respect, the ethnicity and culture of the troubled older individuals being sought out.
References

(The following materials are available from the Spokane, WA, program, c/o Dr. Julie Jensen.)


**Promising Practice:**

**PATCH, Baltimore, MD**

Gatekeepers in congregate public housing identify elders in need of mental health or substance abuse treatment and notify intervention personnel, who go to the site, assess the individuals, provide brief on-site treatment, and refer for more intensive treatment.

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**Sponsoring Organization**
The project is led by the Johns Hopkins School of Medicine’s Department of Psychiatry in collaboration with its School of Public Health’s Department of Health Policy and Management, the Baltimore City Mental Health Department, the Mental Hygiene Administration of the State of Maryland, and the Housing Authority of Baltimore City.

**Demographics**
The program primarily serves an inner-city area with a significant population of older adults and African Americans. Residents evaluated in the initial study phase of this program were predominantly female and African American, lived alone, and had incomes of less than $7,000 per year. Mean age was 72.4; 25 percent were at least 80 years old.

**Recognition**
Articles in peer-reviewed journals, including the *Journal of the American Medical Association*, describe outcomes achieved by program participants compared with similar populations not involved in the program. Detailed outcome assessments have helped demonstrate the value of the program and have contributed to replication of the program throughout the State of Maryland.

**About the Promising Practice**

PATCH, or Psychogeriatric Assessment and Treatment/Teaching in City Housing, is a mobile treatment program that serves elders living in high-rise public housing sites throughout Baltimore. It combines elements of the gatekeeper model and the mobile treatment model that brings treatment to older people at places that are convenient for them.

**How It Works**

**Outreach and Recruitment**
An 8-week education program is provided to staff working in congregate public housing, among them building managers,
janitors, and tenant services workers. Those staff members serve as “case finders,” referring individuals about whom they are concerned to a nurse who visits each site weekly.

**Services**
Initial evaluation focuses on a tenant’s perception of the situation. Over one or more subsequent visits, the nurse obtains a psychiatric history, medical history, and family social history. Blood pressure and pulse are recorded, as are the medications currently being used by the tenant. The CAGE questionnaire is administered to screen for potential alcohol abuse or misuse. Activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are also measured. A depression scale, the Montgomery-Asberg Depression Scale, is used to measure mood, and the Mini-Mental Status Examination assesses cognitive ability.

This information and an initial formulation are presented to the team physician. The nurse and the physician then assess the resident in his or her home and develop an individualized treatment plan with specific, time-related goals. The patient and nurse choose from a variety of interventions to meet the chosen goals.

PATCH focuses on assessment, psychotherapy and medications, and “connecting services,” that include providing transportation to medical appointments, arranging for an increase in the level of financial assistance, and linking individuals to other community services, including services for the aging where appropriate. The nurse acts as an advocate for the client in the health care system.

In the initial study phase, the target populations showed substantial dependency. Among 1,303 elderly residents at the four sites, there were 124 referrals, 85 completed evaluations, and 585 follow-up visits. Interventions included immediate psychiatric hospitalization, some with emergency petitions; referral for alcohol treatment; referral to local community health centers or alternative sources of care; medical evaluation for dementia; treatment for medical problems; and referral to medical day care programs. A significant number of the individuals agreed to regular visits from the nurse.

**Monitoring and Reassessment**
The goal of the program is that after 6 months of work with individuals, 75 percent of those in need of care will attend the clinic (the Geriatric Psychiatry Outpatient Clinic at the Johns Hopkins Hospital or Bayview Medical Center) or use other services. Some residents need ongoing care in the home. PATCH involvement is terminated when a system that provides needed resources is in place.

**Program Assessment**
A recent assessment (Rabins et al. 2000) found a significant decrease in depression and other mental illness in residents of housing units included in the PATCH program, compared with those in other units. The assessment also examined quality of life, knowledge, attitude, and behavior.

Of special interest is the high prevalence of previously untreated psychiatric morbidity in this setting, and the accuracy of the congruence between the referring individual’s identification of the problem and eventual diagnosis. The findings illustrate that the “recognition of psychiatric symptoms by housing management does not necessarily lead to eviction and may instead serve as a route of access to appropriate treatment” (Roca et al. 1990).

In subsequent studies of the population served by PATCH, many findings related to the need for mental health and substance abuse services as well as to implications for
service delivery. For example, follow-up research on alcohol abuse within this population found that “the high prevalence of alcohol disorder and its strong influence on mortality in this predominantly African-American female population demonstrate the need for programs designed to prevent and treat alcoholism in public housing developments for the elderly” (Black et al. 1998a). Another study found that elderly residents of public housing suffer higher rates of psychiatric morbidity than older people living independently in the community (Rabins et al. 1996).

In addition to high rates of psychiatric morbidity among older residents of public housing, research has shown that many of these individuals are not receiving the mental health or substance abuse services they need. Black and colleagues, for example, found that 37 percent of the sample studied needed mental health services, and that 58 percent of those had unmet needs. This unmet need is of particular concern, given the fact that functional status and mental status are major contributors to nursing home placement (Black et al. 1997; Black et al. 1999).

In contrast to elderly African Americans in general, those in public housing tend to rely on formal rather than informal sources of care for mental health problems, although neither source of care fills the unmet need. In response, “interventions to increase identification, referral, and treatment of elderly public housing residents in need should target general medical providers and clergy and include assertive outreach by mental health specialists” (Black et al. 1998b).

Findings also indicate that treating emotional distress may prevent unnecessary hospitalization, homelessness, and premature nursing home placement. In addition, treating emotional disorders may improve residents’ adjustment to and acceptance of aging. Improving life satisfaction in psychologically ill residents may also have subsequent effects on the life satisfaction in psychologically well residents (Cook et al. 2000).

**Linkages**
The PATCH project combines the efforts of many public and a few private agencies, including the Johns Hopkins Departments of Psychiatry and Health Policy and Management, the Baltimore City Mental Health Department, the Mental Hygiene Administration of the State of Maryland, and the Housing Authority of Baltimore City. Linkages are documented in written agreements identifying the roles and responsibilities of each organization. Care is coordinated among these and other agencies, as well.

**Resources and Funding**
Funding is primarily from the State Department of Mental Hygiene. Costs of about $100,000 per year support staff salaries. In addition, research grants have supported program evaluations. Additional information on resources and funding for the PATCH program can be obtained from the program directly.

**Getting Started in Baltimore**
The program was initiated in 1986 because of the significant numbers of older psychiatric patients from public housing coming to the hospital for care. In time, it has expanded. Nonetheless, the program operates, as described above, without significant change.

**Getting Started in Other Communities**
The State of Maryland has supported replication of the PATCH program in four additional sites in Baltimore, Montgomery County, western Maryland, and
The new programs have not been linked to Johns Hopkins. PATCH nurses have had some involvement in the startup of the other sites. For the purpose of replication, a full-time nurse and at least one-tenth of the time of a psychiatrist are required.

Materials available to aid in understanding the program include project descriptions and brochures as well as the journal articles listed under References below.

**Keys to Success**

A key element in the PATCH program’s success is the role of the nurse in the therapeutic relationship. The nurse, more than a social worker, police officer, or case manager, can gain entry, establish rapport, build trust, and begin to help with the complex health problems of the potential clients. Trust and the supporting relationship are at the heart of the program.

According to a program description, achieving the goals of the PATCH program requires two complementary changes. Residents and their families need assistance and encouragement to use community resources effectively. At the same time, these potential resources need to understand the needs of older adults with mental illness.

Cultural competence is another key to the success of the PATCH program. In particular, because the target population is primarily African American, staff sensitivity to the cultural values and health care practices of the African American community has been essential.

**References**


Promising Practice:

Geriatric Regional Assessment Team, Seattle/King County, WA

An interdisciplinary mental health team provides in-home crisis intervention and helps stabilize elders through linkages with community and aging services.

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Sponsoring Organization
King County Public Hospital District #2, DBA Evergreen Healthcare is a community mental health program offering services in a variety of community settings. Homeless clients, for example, are met and served wherever they choose—a community center, a restaurant, even a tavern. Although called a center, the program does not operate a clinic.

Demographics
King County is a major metropolitan area in the Northwest, a prosperous area, rich in services, with responsive local governments. It is a center for the high-tech industry. The county covers 2,131 square miles and has a population of 1.8 million, 13 percent of them elders.

Among the older adult population in the county, 3 percent are Asian, 9 percent African American, 5 percent Hispanic, and 0.5 percent Native American. There also has been a recent influx of Eastern Europeans, especially Russians.

Recognition
In June 1999, The Seattle Times published an article about an interdisciplinary team started by the police department that includes the geriatric team. It highlighted the importance of collaboration among the police, attorneys, protective services workers, and geriatric specialists in handling cases of domestic and elder abuse.

About the Promising Practice
Evergreen Health Care sponsors Geriatric Crisis Services, a specialized crisis intervention and stabilization service available to older adults in the Seattle area of King County. The service is provided by the Geriatric Regional Assessment Team that includes a nurse, geriatric mental health specialists, and a psychiatrist. The team works collaboratively to provide in-home medical, psychosocial, and functional assessments for persons age 60 and older.
who are in crisis, who are not currently enrolled in the mental health system, and who meet eligibility criteria.

To meet the criteria for service, the individual must be one or more of the following:

• physically or medically compromised
• lacking support to ensure health and safety
• resistant to necessary services
• at risk for involuntary psychiatric hospitalization
• in need of an assessment for differential diagnosis

Typically, clients are isolated, hidden older adults—about to be evicted or already homeless, suffering from dementia, dependent on the care of neighbors, referred to the health department because of the unsanitary environment in which they live, or alienated from other people.

How It Works

Program services include:

• assessment
• crisis intervention and stabilization
• prompt referral and linkage to providers
• consultation
• guardianship evaluations
• care planning
• education for professionals, families, and other care providers

Outreach and Recruitment

Most clients come to the program’s attention through reports from neighbors, police, health department workers, or other people with whom they come in contact.

Services

The assessment is comprehensive, covering psychiatric, medical, social, and functional domains. Screens include the Geriatric Depression Scale and the Folstein Mini Mental State Exam. Assessments are conducted by the Geriatric Regional Assessment Team. Team members explore clients’ religious beliefs and cultural values as part of the assessment process, if the client is open to the discussion.

Team members educate the client, family, and caregivers about the diagnosis and medications, and refer the individual to appropriate agencies and support groups. The agency accepting the referral develops a service plan. Following assessment and referral, the team stays involved until the crisis is stabilized. Most often, referrals are made to the Aging and Disability case management program, medical clinics, the Alzheimer’s Association, Adult Protective Services, in-home mental health services, and physicians. Many of the clients have not seen a doctor in years.

The team also provides consultation and training for the King County Aging and Disability Services case management program.

Services of the Geriatric Regional Assessment Team are focused primarily on mental health, and clients served are those with mental health needs. The staff, for example, includes a nurse with a background in gerontology, mental health professionals, and a psychiatrist who is available half a day each week for home visits and case consultations, and otherwise available for emergency consultation by phone. Services include assessment, diagnosis, crisis intervention and stabilization, counseling, medications, and referral.
Until recently, substance abuse and mental health were handled by separate departments, but now they have been combined in the County Mental Health Department, promising greater integration in the future. Currently, if the Geriatric Regional Assessment Team identifies a client with only a substance abuse problem, the team refers that person to substance abuse services.

**Monitoring and Reassessment**
Ongoing monitoring and reassessment are carried out by the agencies to which the individual has been referred. The client may easily be re-referred if a change in condition occurs.

**Linkages**
The program works closely with aging and disability services, adult protective services, police departments, senior information and referral, the involuntary mental health team, voluntary geropsychiatric units, physicians’ clinics, and private physicians. Team members also serve as informal consultants to the agencies they work with. Most linkages are informal, but there are four formal linkages through contracts with aging and disability services (the area agency on aging); a 24-hour crisis clinic; the Senior Information and Assistance Line (the number one source of referrals); and the Homeless Outreach, Stabilization, and Transition Team.

Training is provided to case management staff of the area agency on aging and to the Adult Family Home Network. Training also is offered in conjunction with the University of Washington Social Work Department, and through the University of Washington’s Institute on Aging, which provides rural education throughout the Northwest.

**Program Assessment**
Quality assurance case reviews are conducted quarterly. Outcomes considered are primarily service-related. Because most of the clients have undiagnosed dementia and are not surveyed for consumer satisfaction, the referring agencies are surveyed annually, and the information provided by case managers is used to make program changes.

Reviews, including the annual reviews by the State and county, are outstanding. The parent hospital is accredited by the Joint Commission on the Accreditation of Healthcare Organizations, whose representatives decided not to include the crisis services in the most recent survey.

Case reviews are peer assessments. All team members participate in every quarterly review. The value is both in team-building with new staff and in ongoing team education with questions, answers, and brief discussion. There may be longer discussions at team meetings, based on interest or need. An additional benefit is the fact that individual problems are caught early in the process.

**Resources and Funding**
The services are funded by King County Mental Health and, therefore, are provided without charge to clients and families. The terms of the county contract include a guaranteed response time of 3 days—a recent increase from a 2-day response, necessitated by an increase in referrals without an increase in funding.

Interestingly, neither a clinic nor extensive office space is necessary. However, laptop computers are needed to enable delivery of services in multiple community settings.

The program can provide additional information on its resources and funding.
**Getting Started in Seattle/King County**

In 1992, King County formed a planning and advisory committee of mental health and aging representatives to evaluate the existing geriatric mental health system and to develop an improved continuum of services for older adults. Work groups looked at models from around the country. The county initiated a request for proposals and eventually contracted with Evergreen Healthcare, a division of Evergreen Hospital and Medical Center. The Geriatric Regional Assessment Team was formed in 1994 and has had an increasing number of referrals each year.

The number of admissions to team services has also increased steadily. In 1997, admissions averaged 19 a month; in 1998 the average was 29 a month; in 1999, 31; and by September 2000, 37. Demographics suggest that the numbers will continue to increase.

As the program has evolved, there have been a few changes. At one point, extra funding was provided for a 24-hour crisis stabilization function, but after only a 6-month trial, that component was dropped. Initially, staffing included a number of part-time workers, but that has changed to stabilize the program’s staffing and service delivery. At this time, staffing includes 3.8 full-time professionals.

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**Getting Started in Other Communities**

The clinical director believes that this program can be offered in other settings and makes himself available for consultation to sites interested in replication. Beyond the interest in establishing such a program, successful implementation required availability of staff and adequate funding. Staffing in Seattle is very lean, with 3.5 clinicians and 0.3 time for a supervisor/administrator; additional staffing is recommended. Feedback from participants in the program is very positive.

**Materials**

A comprehensive assessment and intake form, a quality assurance case review form, an annual referral source satisfaction survey, and a sample curriculum outline are available and convey a strong sense of the quality of the program.

**Keys to Success**

As identified by the team, the keys to success include free services; flexibility; strong, experienced clinicians; quick response to those making referrals; and a creative approach to initial encounters.

Team members develop cultural competence through taking part in annual cultural sensitivity training and through consultation when needed.
Introduction

Because of their daily proximity to older adults, aging services providers are well positioned to be actively involved in screening older adults for substance abuse and mental health problems and referring them to skilled professionals for further assessment and treatment. Early intervention and treatment can dramatically improve the lives of these adults. This section describes programs that focus on the process of screening—determining whether it is likely that a person has a given problem—and organizing referrals to facilitate treatment for identified problems.

The aging services programs profiled in this section are successfully screening and referring older adults with mental health and substance abuse problems. Some also offer intervention and treatment. Although not all aging services can offer the full array of services, it is important for aging services staff to recognize the value of creating linkages with treatment providers in the community or regional area.

Screening is a preliminary assessment or evaluation that attempts to measure whether key features of a given problem (e.g., substance abuse or mental disorder) are present in an individual. This process does not yield a clinical diagnosis. Rather, it indicates whether there is a probability that the condition looked for is present. A comprehensive assessment, on the other hand, is a thorough evaluation, the purpose of which is to establish the presence or absence of a specific diagnosable disorder or disease.

Recommended treatment interventions for alcohol and medication misuse/abuse among older adults have been outlined in the Substance Abuse Among Older Adults, Treatment Improvement Protocol Series #26. Treatment for problem drinkers may include detoxification, inpatient or residential rehabilitation, or outpatient services. Treatment approaches for older adults may include cognitive-behavior approaches; group-based approaches; individual counseling; medical/psychiatric approaches; marital and family involvement and family therapy; and case management/community-linked services. Research shows that older people who misuse alcohol can reduce alcohol use successfully after a brief intervention by a trained clinician, social worker, home health care worker, or professional counselor.
Mental Health: A Report of the Surgeon General discusses approaches to treating mental disorders among older adults. These approaches include pharmacological interventions as well as psychosocial interventions. While the pharmacological and psychosocial interventions used to treat specific mental disorders among older adults may be the same as those for younger adults, characteristics unique to older adults are important considerations in treatment selection. Physiological changes due to aging must be considered in selecting appropriate medications and dosages for older adults. These changes include increased vulnerability to side effects, the potential impact of multiple medications, potential interactions with other disorders, and other age-related barriers such as impaired vision (which may make it difficult for the older adult to read instructions on the label) or cognitive impairment. Several types of psychosocial interventions have been proven effective with older adults, though the research is more limited than that on pharmacological interventions. In addition to helping address the symptoms of many mental disorders among older adults, psychosocial interventions also can help strengthen coping mechanisms and promote healthy behavior.

Promising Practices in Screening, Referral, Intervention, and Treatment

Many older adults prefer to receive treatment for mental disorders from their primary care providers. One of the promising practices profiled here offers mental health and substance abuse services in the context of a primary care setting. Another offers these services in a multifaceted senior service center. A third collaborates with aging services to reach out to older adults and to offer screening, referral, and treatment support services. In each instance, linkages with community partners have resulted in the effective delivery of needed services. One of the practical lessons from these programs is that it is preferable to offer these services in a comfortable and natural setting for the older adults in need.

Implications for the Aging Network

These promising practices show that, through the creation of links with community partners, aging services can help older adults identify mental health and medication and alcohol-related problems and seek appropriate help. Because the practices are built on community linkages, they can be instituted without requiring aging services staff to become either experts in the field or direct treatment providers. Through partnerships, these programs have helped meet the needs of elders without major commitments of time or resources.

Resources

The screening tools used by many of the promising practices in this publication are identified in the program profiles. Some of the screens most commonly used are those for dementia, because presenting behavior is often thought to be related to dementia. Screens that check for depression in older adults also are frequently used by the programs profiled in this
section. One of the simplest is the Geriatric Depression Scale. The Center for Epidemiologic Studies Depression Scale (CES-D) is another depression screen used by some of the programs profiled here.

The Michigan Alcoholism Screening Test–Geriatric Version (MAST-G) is a screen specifically designed to test for alcohol misuse in older adults. The full screen (24 questions) and a short version (10 questions) have both been tested and validated for use with older adults. The MAST-G can be used as a self-screen. Several of the programs profiled in this publication use the CAGE questionnaire. This four-question screen is not as useful with older adults as either version of the MAST-G, but it has the advantage of being quite short.

The Geriatric Depression Scale, the CES-D, the long MAST-G, and the CAGE are described and replicated in the publication, *Substance Abuse Among Older Adults: Treatment Improvement Protocol Series #26*. This publication is part of a series of publications (also known as TIPs) providing best practice guidelines for the treatment of substance abuse. The TIPs, published by the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Substance Abuse Treatment, are available free of charge from SAMHSA’s National Clearinghouse for Alcohol and Drug Information (1-800-789-2647). The short version of the MAST-G was developed after TIP #26 was published and was, therefore, not included in the TIP. It is, however, reproduced in Appendix 5 of this publication.

Appendix 2 includes contact information for several national organizations that have assisted SAMHSA and NCOA in developing this guide. These organizations may be of assistance to identify State or local resources. Many of them have State or local affiliates which can be identified through their web pages.
Promising Practice:

Kit Clark Senior Services, Boston, MA

Multiservice agency offers mental health and substance abuse screening, treatment, and long-term support for seniors.

Contact:
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Sponsoring Organization
Kit Clark Senior Services is a multipurpose elder services agency providing a full spectrum of services to Boston’s senior community. It is a multiethnic and multilingual, community-based agency whose mission is to enable older adults to maintain themselves with dignity in the community.

Kit Clark offers mental health and addictions services that include assessment and treatment planning; individual and group therapy; case management; outreach and home visits; and information, referral, and education for seniors, family members, community groups, and service providers. Other services include transportation; nutrition programs and home-delivered meals; home repair; housing and homeless programs; exercise, health education, and other classes; adult day services; primary health care; and social opportunities.

Demographics
Kit Clark’s constituents number around 4,000 seniors living throughout the greater Boston area. Seventy-eight percent of the seniors served are 65 or older; 22 percent are under 65. Fifty-seven percent are female; 43 percent are male. Forty-one percent are Caucasian; 40 percent are African American; 11 percent are Asian; and 7 percent are Latino. At least 85 percent of constituents are of low income. Common languages spoken at Kit Clark include English, Vietnamese, Spanish, Haitian Creole, and Cape Verdean Creole. Approximately 25 percent of constituents are homebound.

Recognition
Kit Clark is seen as a leader in the field of geriatric substance abuse, gambling addiction, and mental health services. Its programs have been featured in several documentaries and training videos, including “It Can Happen to Anyone: Problems with Alcohol and Medications Among Older Adults,” produced by AARP and the Hazelden Foundation in 1996; and “The Doctor Is In: Substance Abuse in the Elderly,” produced by Dartmouth-Hitchcock Medical Center for PBS in 1999. It also has been featured in major newspapers including The New York Times,
the Boston Herald, and the Boston Globe. Its staff have made presentations to professional and community groups in the United States and Canada.

About the Promising Practice

Kit Clark Senior Services believes it takes community collaboration to address addictions and mental health problems of older people. Working closely with other service providers and the community, Kit Clark has created a network that is responsive to seniors’ mental health and addictions issues. As a result, elders throughout Boston are more likely to learn about and participate in prevention, intervention, and treatment opportunities. Kit Clark collaborates with the area agency on aging, home care corporations, clergy, hospitals, and others. It has trained outreach workers, direct care staff, and administrators of aging services to recognize substance abuse and mental health issues, discuss them with older adults, and make referrals.

Kit Clark Senior Services offers outpatient treatment programs for older adults with addictions or mental illness. Its Geriatric Mental Health Clinic has operated since 1980, Alcohol and Substance Abuse Services for Older Adults since 1981, and Gambling Treatment for Older Adults since 1997.

The Kit Clark programs are part of the agency’s continuum of services. Most clients come in not only for individual or group sessions, but also to socialize in the senior center, have a meal, and receive other services. Kit Clark strives to offer a community that accepts and values its participants while helping them decrease social isolation and loneliness. Its clients are in varying stages of recovery—from individuals who have been identified as having a problem but are in denial to those who have maintained sobriety for many years.

Recognizing that individuals have different needs, the center’s staff remain flexible and tailor an approach to each individual. The staff of the addiction programs include social workers with expertise in addictions, mental health, and aging.

The caseload varies from 40 to 60 clients at any given time. Since 1981 more than 2,000 individuals have received clinical services and thousands more have participated in outreach and education activities. The usual length of addiction treatment is 2 to 3 years. Treatment tends to be relatively long-term, intense during the early stages and decreasing as clients recover. Many seniors remain engaged, serving as volunteers or taking part in relapse prevention services.

How It Works

Outreach and Recruitment

Referrals for mental health and addictions programs come from the more than 35 programs offered throughout Boston by Kit Clark Senior Services. Staff in all agency programs are trained to identify addictions and mental health problems, talk with individuals about their concerns, and refer them for services. Staff also provide ongoing support to seniors, encouraging them to get help or to continue the recovery process. Staff members include home health aides, adult day services staff, housing counselors, senior center staff, and other staff with direct contact with seniors. Clinical social workers, outreach workers, and student interns make home visits to isolated individuals. Referrals also come from external service providers such as case managers, senior housing
managers, home health care nurses, discharge planners, and primary care physicians.

Outreach and training are conducted with other agencies and community groups to create a safety net for seniors with mental health or addictions problems. The attitudes and the stigma associated with mental illness and addictions among older people must be overcome so people can identify and refer seniors for services.

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.

Services
Each senior is offered a comprehensive health and social needs assessment—the Senior Health Education and Access Assessment (SHEA)—which is being developed collaboratively among Kit Clark Senior Services, Tufts Senior Health Maintenance Organization, and Beth Israel Deaconess Medical Center. It uses a detailed client tracking system to assess progress in meeting client needs. During the intake process, a complete social and health history is taken, and clients undergo screenings for mental status, gambling addiction, and substance abuse. If a problem is detected, a more detailed assessment is completed, including the MAGS (Massachusetts Gambling Screen) and the Michigan Alcohol Screening Test–Geriatric Version (MAST-G). Information from collateral providers and family members also is collected. An interdisciplinary team of clinical social workers, a psychiatrist, and a nurse work with the seniors to develop a treatment plan based on the client’s assessment information. Clients are connected with the other programs that Kit Clark provides and coordinates—primary health care, nutrition, transportation, and adult day services. Referrals are made to other sources as needed.

Kit Clark mental health and addictions programs provide individual and group therapy, outreach, and psycho-education. These services also are provided in home visits for older adults who are unable to come to the center. Self-help recovery groups meet regularly at the Kit Clark senior center.

Substance abuse and mental health services are offered in a supportive stigma-free environment. Because of all the other programs going on at the center at any given hour, there is also a great deal of anonymity.

On a typical day, a client may move through a number of activities, some directly related to mental health and substance abuse, others not. For example, a client might attend an individual therapy session, go to an exercise class, have lunch with friends, and then attend a computer class. The next day the same client might take part in a therapeutic group session. Transportation services often are an essential ingredient for success.

Kit Clark Senior Services reaches diverse populations and pays special attention to cultural competency and language needs. Bilingual, bicultural staff conduct both treatment and social groups for Vietnamese, Cape Verdean, Haitian, and Hispanic seniors.
Monitoring and Reassessment
The interdisciplinary staff team reviews the progress of each participant quarterly, at which time care plans are updated and revised. As part of the treatment plan review, there is a multiaxial assessment of the client’s status. Client progress is reported monthly and results are evaluated based on the outcome indicators of the logic model (see Program Assessment below). Service and programmatic outcomes are a critical component in the logic model.

Linkages
Kit Clark Senior Services has established both internal and external linkages. The mental health and addictions programs are integrated into the continuum of care within the agency. SHEA provides a comprehensive health and social assessment for clients in the mental health and addictions programs to link them to other needed services. This tool also is used in other Kit Clark programs. It can identify existing or potential mental health or addictions problems so that seniors can be referred for further evaluation.

Kit Clark participates in the monthly meetings of the Massachusetts Geriatric Substance Abuse Task Force. Other addictions and senior service providers, the Massachusetts Department of Public Health, and the Executive Office of Elder Affairs collaborate to address issues of awareness, funding, policy, and resources. The agency works collaboratively with the Boston Commission on the Affairs of the Elderly (the Boston area agency on aging) and other community resources to improve awareness and identify seniors in need of help.

Program Assessment
Kit Clark Senior Services uses the United Way of America’s Logic Model and Outcome Measurement Plan. A logic model is a conceptual map of the program, describing program inputs, activities, outputs, initial outcomes, intermediate outcomes, and long-term outcomes. An outcome measurement plan outlines the process and progress for tracking one or more desired outcomes. The measurement plan tracks the desired outcome, indicators, influencing factors, and details on data collection.

Outcome indicators are used for program improvement, strategic planning, and reporting purposes. Examples of particular outcome indicators measured by Kit Clark are the following:

- Concurrent medical problems are addressed.
- Environmental stressors are addressed.
- Global assessment of function improves or maintains.

Resources and Funding
Services are paid for through insurance reimbursement that includes Medicare and Medicaid, and through funds from the Massachusetts Department of Public Health Bureau of Substance Abuse Services. Additional foundation and grant money is required to cover total costs of programs. The program can provide additional information on its resources and funding.

Getting Started in Boston
Over the 20 years that Kit Clark has offered mental health and addictions services in Boston, the integration of these services into other Kit Clark programs and with other Boston providers has been essential for
success. Once clinical programs were established, other agency services were added to create a multidimensional approach and to reach an optimal number of elders. There was also a focus on building the whole community’s capacity to offer prevention, intervention, and treatment to elders with mental illness and addictions. Throughout the City of Boston and the Commonwealth of Massachusetts, Kit Clark Senior Services is a collaborator and resource to address mental health and addictions issues for seniors.

**Keys to Success**

The message from this comprehensive service program is that it “takes a community to address addictions and mental illness with this population.” While research has shown that older people do well in treatment, the Kit Clark program has found that they often do not enter treatment without:

- repeated mentions of the problem by the client’s friends and family
- addressing the client’s entire life
- ongoing support
- plenty of time and patience to build a relationship and establish trust

**Getting Started in Other Communities**

Several key components are needed to replicate this program in other communities:

- outreach to seniors through one-to-one contact and group education
- collaboration among agencies and services that have contact with elders
- identification and intervention training for staff and community members
- a referral network that can address the range of needs of seniors with mental health and addictions problems
- a linkage to a mental health clinic and a psychiatrist because of the frequency of dual diagnoses

Extensive training and outreach materials have been developed. They include multilingual brochures, satisfaction surveys, curricula and handouts for nonclinical staff to use in making presentations, handouts for elders, intake and assessment forms, and staff training materials. An excellent curriculum has been developed, *Passing It On, A Handbook for People Who Care About Elders*. It offers practical information on medications, tobacco use, alcohol, intervention, HIV/AIDS, and stress.
Promising Practice:

Over 60 Health Center, Berkeley, CA

Community health center integrates mental health and substance abuse services with primary health care and also provides referrals to community mental health and substance abuse services.

Contact:
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Lifelong Medical Care
P.O. Box 11247
Berkeley, CA 94712-2247
Phone: 510/704-6010, ext 261
Fax: 510/883-1667
email: martyl@lifelongmedical.org
web site: www.lifelongmedical.org

Sponsoring Organization
Lifelong Medical Care, a federally qualified health center (FQHC), was founded by the Gray Panthers 25 years ago to provide primary care and comprehensive health services. It was formed when the original Over 60 Health Center Corporation merged with two other health centers. Lifelong includes five licensed sites, three of which are Over 60 Health Center sites, and a satellite site.

Using an interdisciplinary team approach, Over 60 Health Center sites offer “one-stop shopping” for a full range of services including health promotion, disease prevention, screening, diagnosis, and treatment. Though mental health has been part of the program since the mid-1980s, mental health and substance abuse services have become more significant in recent years.

Demographics
Among the clients served by Over 60 Health Center sites, the average age is 78; women outnumber men two to one; 60 percent are African American, 30 percent are Caucasian, and the remaining 10 percent are Asian and Hispanic. A significant number are homeless, 95 percent have incomes below 200 percent of the Federal poverty level, and many are below 100 percent. Most have several chronic diseases, and depression is not uncommon.

Recognition
Center Director Marty Lynch received the Robert Wood Johnson Foundation Community Health Leadership Award for his work with the Over 60 Health Center. Over 60 has received special recognition from the America Society on Aging, Sisters of St. Joseph of Orange, and others.
About the Promising Practice

The Over 60 Health Center combines primary care and mental health services so consumers do not have to travel to receive treatment. It is the first community-based geriatric health care center in the country, and it has always offered an integrated and multidisciplinary system of health care service delivery. All of the primary care physicians are trained to recognize mental health issues. The center uses a consumer-directed approach in offering its mental health and substance abuse services.

How It Works

Outreach and Recruitment
As a long-established health center, Over 60 draws older consumers from throughout the community. Many are referred by community organizations and private physicians. Others are attracted to the clinic through the health education programs on mental health, exercise, smoking cessation, weight control, and hypertension that Over 60 conducts in senior centers.

Community programs referring to Over 60 include South Berkeley Senior Center, Bay Area Community Services Meals-on-Wheels, Alzheimer’s Services of the East Bay, Emeryville Senior Center, Legal Assistance for Seniors, and the Alta Bates Hospital emergency room.

Services
Physicians providing primary care in the Over 60 Health Center conduct an informal screen during patient visits and make appropriate referrals to mental health clinical staff. The primary care physicians and the mental health clinical staff, including psychologists and social workers, share responsibility for treatment planning to ensure that consumers in need of mental health services either get them on-site or are referred and receive treatment.

Physicians and other staff can refer patients to mental health, social, and substance abuse services. Users also can self-refer. Patient needs are assessed in a social work intake process after which an appointment is set with an appropriate provider at Over 60 or a referral is made. Users may be referred to outside services if internal capacity is at its limit or if the patient’s insurance requires it. Complexity is not normally a reason for referring out.

Over 60 offers assessments, individual and group counseling, medication management, Alzheimer’s disease diagnoses, and behavioral health services. Alcohol treatment will soon be provided on-site. Lifelong Medical Care offers a range of services, some of which are available to Over 60 clients—such as acupuncture treatment to support detoxification and maintenance of sobriety. The Over 60 interdisciplinary team includes a clinical social worker, a clinical psychologist, and a primary care physician, in addition to a nurse.

Over 60’s consumer-directed approach to mental health services is reflected in its 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.

Lifelong Medical Care, working with the University of California at San Francisco, is a site for a national demonstration project funded by the Substance Abuse and Mental Health Services Administration that compares the effectiveness of integrating mental health and substance abuse services with primary care to the effectiveness of a traditional referral model. The goal is to enroll 150 to 200 individuals, serve one group directly, and refer the other to a service provider in the community that has been used successfully for referrals in the past.

This project provides an opportunity to supplement services, collect outcome data, and examine the effectiveness of services integration in contrast to referrals. Mental health services focus on individuals with depression and anxiety, excluding those with more severe diagnoses. SAMHSA and the Health Resources Services Administration are funding this project, which is also being conducted in six other primary care sites and five Veterans Administration sites. The study is looking specifically at depression and anxiety and alcohol use. Although people with psychoses are excluded from the study, they still receive the services.

**Monitoring and Reassessment**

Ongoing monitoring and reassessment is provided by five social workers who serve 50 clients on a monthly basis.

**Linkages**

Over 60 has worked closely for 20 years with the area agency on aging and with the coalition of providers in the aging services network. The center also maintains close connections with other community health centers and community service providers. These relationships foster consumer referrals and joint program efforts. Cooperative endeavors include providing legal assistance and medical services to individuals who are served by the Meals-on-Wheels program. For example, if problems are detected in the Meals-on-Wheels application, elders are referred to case managers who conduct home visits and arrange for needed services. Because of this process, some in-home mental health services are being provided.

The medical center has active linkage with numerous community organizations, including a demonstration project in which teams offer mental health, substance abuse, and health care services in single resident occupancy hotels where many older adults reside.

Through another partnership, Over 60 is developing a package of care for individuals at high risk but not yet eligible for the Medicaid-supported Program for All-inclusive Care for the Elderly (PACE). Initial funding has come from the Robert Wood Johnson Foundation and the California Endowment. The State health department is also considering support.

Over 60 has moved to a new building to partner and collocate with the Center for Elders Independence, operated by the national PACE program, and with the Department of Housing and Urban Development’s program that provides funding for very low-income senior housing sponsored by a local nonprofit housing developer.
Program Assessment
Over 60 collects outcome data in all categories: quality of life, including health and functional status; knowledge, attitude, and behavior; service-related; community-level; and cost/utilization. When the Center surveyed the patients served, feedback consistently showed they were most satisfied when someone was willing to take time with them.

Lifelong and Over 60 are licensed and monitored by the State as community clinics. In addition, because Lifelong Medical Care is an FQHC, the Federal Bureau of Primary Care monitors with its extensive Primary Care Effectiveness Review (PCER). The PCER includes data on diagnoses, payer mix, and nine measures of compliance.

Resources and Funding
The primary source of funding for these services is third-party reimbursement from Medicare and Medicaid (at rates established for FQHCs), Older Americans Act funds from the area agency on aging, demonstration projects, other grants, indigent care funds from the county, and other fund-raising efforts. The program can provide additional information on its resources and funding.

Getting Started in Berkeley
The Over 60 Center was established as an outpatient clinic in the mid-1970s, because the founders wanted to offer a community-based alternative to the nursing home care that many older adults were receiving. The first services offered were “preventive.” Nurses worked directly with older adults to manage chronic conditions and handle such mental health problems as depression and anxiety. Primary care services were added later, when it became evident that the patients served did not have or did not see physicians on their own.

In the 1980s a geropsychologist was added to the staff, as were short-term therapy and assessments. The interdisciplinary team approach continued, and assistance with practical problems became part of the services offered. As mental health services evolved, the services of a clinical social worker, an additional clinician, and a substance abuse counselor were added.

Getting Started in Other Communities
Community health centers throughout the country are making new efforts to serve elders. This presents aging services the opportunity to create linkages to increase community health and mental health services. Some communities could bring together a PACE program, a multiservice organization, and housing; others can apply the principles of Over 60 to meet their goals.

Over 60 uses physicians, nurse practitioners, physician assistants, and medical support. It also uses a psychiatrist, social workers, and geriatrically trained clinical psychologists. For FQHCs, clinical social workers are a covered benefit under Medicare and Medicaid; they are not covered under traditional Medicare. Over 60 also uses a certified substance abuse counselor for individual and group work. The director believes that a health center could begin an integrated approach with a good licensed clinical social worker.

Descriptive materials are available.
**Keys to Success**

- One key is FQHC status. Lifelong Medical Care is a community health center charged with providing a range of services in a medically underserved area and is overseen by a consumer-directed board. It receives this designation through the Public Health Service's Bureau of Primary Health Care and benefits from somewhat increased Medicare and Medicaid reimbursement.

- Another key is consumer direction. Consumers comprise the majority on Lifelong’s board of directors.

- A third key is cultural competence, for the program as a whole and for its specific projects. Hiring and training emphasize the importance of maintaining the capacity to “effectively reach, serve, and satisfy an ethnically diverse community, the majority of whom are African American.” When necessary, changes are made to ensure cultural competence. For example, efforts are under way to refine the screening instrument for the integration project to ensure the inclusion of all ethnic groups.
Promising Practice:

Elder Substance Abuse Outreach Program, Chicopee, MA

Geropsychiatric agency collaborates with aging services to reach elders with substance abuse problems and offers screening, referral, and treatment support services.

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Maureen Perreault
Hawthorn Services, Inc.
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Chicopee, MA 01020
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Fax: 413/594-8693
email: hawthorn99@aol.com
web site: www.HawthornServices.org

Demographics
The elderly population in Chicopee is primarily Caucasian and African American. There is a growing Hispanic population in nearby Holyoke. They are served by a substance abuse counselor who speaks some Spanish and works closely with local providers accepted in the community.

In the first two years of operation, 50 referrals were made to the Elder Substance Abuse Outreach Program—26 men and 22 women. The age range of clients was 58 to 92, but most were in the range of 68 to 75. Currently, the weekly support group is economically mixed and includes a retired physician as well as blue-collar workers.

Sponsoring Organization
Hawthorn Services is a multiservice geropsychiatric organization that has been in place for 20 years. In addition to the Elder Substance Abuse Outreach Program, Hawthorn offers a residential program providing a structure for elders who need 24-hour care while maintaining a flexible system to accommodate a wide range of needs and levels of functioning. In addition, a community elder support program serves mentally ill elders who live independently in the community. A wide range of services are offered directly. Additional services are provided by other community organizations while collaboration is maintained to provide comprehensive services.

Recognition
In 1993, Hawthorn Services received a Partners in Eldercare Award from AARP and the Administration on Aging. Its programs were presented as models at the 1991 annual meeting of the American Society on Aging and the 1994 annual meeting of the Gerontological Society of America. They were also referenced in the 1999 Mental Health: A Report of the Surgeon General. In 1995 the Outreach Program was chosen by the Judge David L. Bazelon Center for Mental Health Law as a Best Practice.
About the Promising Practice

The Elder Substance Abuse Outreach Program began as a cooperative project between Hawthorn Services and Brattleboro Retreat, an inpatient substance abuse treatment agency. It offers a community-based approach to the treatment of substance abuse for the elderly. The program incorporates three facets of treatment. Working with other community-based agencies, it:

- identifies elders at risk
- uses an experienced clinician to initiate contact with the elder in his or her own home
- offers the support of weekly substance abuse therapy and peer support group meetings

Program components include outreach, individual and group counseling, socialization, peer support, and education.

Care plans are developed for each person referred to the program, and progress is charted. The goal is to use support from professionals and peers to produce a better quality of life for each individual. The program has succeeded in supporting personalized goals, including achieving sobriety, securing appropriate and safe housing, attending literacy classes, and, for some, participation in Alcoholics Anonymous.

How It Works

Outreach and Recruitment
Outreach, or client identification, can begin with a referral from a community organization such as the visiting nurse association, a council on aging, local police department, or local elder housing complexes. When an informed gatekeeper identifies a potential problem, he or she contacts Hawthorn. Usually within 24 hours, Hawthorn dispatches an outreach worker—either the part-time substance abuse counselor (a social worker with substance abuse credentials) or the full-time social worker who also has substance abuse expertise. The counselor's initial contact is an outreach visit to the client's home. The philosophy of the program is to be persistent, anticipating that clients will have difficulty accepting the need for intervention. A number of repeat visits may be necessary to engage the client in a relationship in a nonthreatening and nonconfrontational manner.

Services
The outreach worker makes the initial assessment, often using the MAST-G for substance abuse as well as a depression screen, though instruments and approaches vary case by case. Often the substance abuse problem is confirmed, but occasionally a more thorough assessment detects a different problem. Care plans are developed by the social worker with substance abuse credentials.

Hawthorn is not a crisis program, nor does it provide formal treatment for substance abuse. Its weekly therapy groups try to get individuals to recognize the problem and link up with an appropriate resource.

Hawthorn's Elder Substance Abuse Outreach program includes a therapy and psycho-educational group that relies on education coupled with peer interaction to provide support. Most sessions spend time educating the group on physical as well as psychological ramifications of addiction. Emphasis is not on abstinence but on understanding, finding resources, and reconnecting socially.
Hawthorn always refers those in crisis to an inpatient unit. Staff members do not assist consumers in detoxification or recommend that they accomplish it without professional help. On intake, individuals are encouraged to consider various services available to them. Hawthorn focuses on educating the consumer, as well as providing support and a therapeutic setting.

The program provides a range of services for those dealing with their problem or in need of support, prevention, and relapse prevention. Clients can be seen as often as once a week by the counselor or social worker, and regular contact is maintained with the person who made the referral.

Group counseling includes a weekly substance abuse therapy and peer support group. The meetings, held at the Chicopee Council on Aging’s senior center, are a combination of education, support, therapy, and socialization. This group encourages members to review their past, come to better terms with their current situation, and understand the impact of alcohol on their lives. Socialization is provided at the end of the session, when a meal is offered. This serves as an incentive while providing nutrition and strengthening the community support system.

Peer support complements the counselor visits and group work. Hawthorn Services trains older volunteers recruited by the local councils on aging to provide support to elders with emotional difficulties or depression, often linked to substance abuse. Volunteers receive training before they are placed with an elder; they meet monthly with clinical staff for additional guidance. They also may serve as bridges to treatment.

Hawthorn makes frequent presentations to educate service providers and health care professionals as well as older adults and their caregivers about the prevention, recognition, and treatment of alcoholism and depression in the elderly.

The program also focuses on reaching the gatekeepers, providing in-service training for area agency on aging case managers on such issues as how to identify a potential problem, warning signs of which to be aware, and the services that are available once need is confirmed.

As they have become known in the community, Hawthorn staff have taken on the role of case consultants for other service providers who call for advice and guidance when they detect a problem. Hawthorn helps them distinguish problems of substance abuse from dementia, depression, or medication mismanagement.

Hawthorn also offers a residential program and the Community Elder Support program. These programs are related to the Elder Substance Abuse Outreach program because they have the same mission: to provide whatever services are needed to keep elders active and at home as long as possible and to provide care for those who otherwise would be underserved. The residential and Community Elder Support programs are in a closed referral system controlled by the Department of Mental Health. The residential program is a mental health, rather than a substance abuse, program. If a referred client is dually diagnosed, the problems are addressed residentially and by Elder Substance Abuse Outreach.

The Community Elder Support program differs from Elder Substance Abuse Outreach in that it is primarily a mental health program designed to provide support for older people living in the community. It addresses issues of activities of daily living (ADL) and instrumental ADL issues, as well. Many of the Elder Substance
Abuse Outreach program consumers are treated by psychiatrists or are taking medications for depression.

**Monitoring and Reassessment**
A care plan is developed for each participant that includes general goals that the counselor and the participant will work toward. Each group session is documented so that group members’ progress can be noted. Consumer contact sheets are used for individuals receiving home visits so progress can be tracked.

**Linkages**
Linkages involve:

- services such as the detoxification unit for seniors at Brattleboro
- referrals from the visiting nurses, hospital discharge planners, councils on aging, area agencies, police, and family members
- follow-up services to programs (such as that offered by Brattleboro) and community education
  
  The Elder Outreach counselor spends a portion of each week talking with other agencies to educate them about the program. Periodic in-service training is held at various places such as housing developments and offices on aging to raise awareness of the program and also to alert other agencies about the “hidden problem” and to help them begin to recognize symptoms.

  Under contracts with hospitals for services and many informal arrangements with local agencies and hospitals, Elder Outreach provides education and services and the partners provide the referral and, in some cases, treatment.

**Program Assessment**
Hawthorn is licensed and monitored by the Department of Mental Health. Its residential program is accredited by the national Rehabilitation Accreditation Commission (CARF), and its adult day health program will soon apply for CARF accreditation as well.

  The program has conducted participant satisfaction surveys and collected considerable anecdotal information. There has been no formal collection of outcomes data because of a variety of complicating factors. Because participation in the group is not time-limited, posttests are difficult. Also, some evaluation criteria would consider hospitalization a negative outcome, while others would view it as positive. Staff members feel that increased community awareness and recognition as well as successful linkages to hospitals and community gatekeepers are indicators of success.

**Resources and Funding**
The program’s services are provided without charge, and the program actually began with no funding. The decision not to charge patients came out of the program in Connecticut that served as this program’s model. The clinical social worker on that staff was able to bill Medicare for services, but when the clients received their statements from Medicare that documented the substance abuse services, they stopped the services. Staff believe the stigma of the documented diagnosis and care was too great a barrier. Staff continue to feel that this is an appropriate way to initiate the service and worth the cost of getting the program off the ground.

  Sources of funding include funds from Brattleboro, direct fund-raising efforts, grants from the area agencies, and funds from the Center for Community Recovery
Innovations (part of the Massachusetts Housing Finance Agency) specifically for individuals in public housing. Revenue is expanding now through linkages with hospital systems, thus opening up the potential for funds from the State Department of Public Health for “psycho-educational ambulatory care” covering community-based prevention and education for individuals who have not received inpatient care.

**Getting Started in Chicopee**

The Elder Substance Abuse Outreach program in Chicopee was initiated in 1997. It was modeled after a program in Connecticut that also emphasized aggressive outreach, although that program’s linkage with medical services was more formalized than the Chicopee project.

The impetus for the program was the recognition of unmet need in the community for outreach and assessment and for services specifically geared to older adults. Providers in the community realized that older adults were in need of substance abuse services but that they were not referring themselves to programs, nor were they comfortable in settings dominated by youth. Staff also felt that specialized services were needed because of the link between substance abuse and depression and issues that often led to or exacerbated the problem, such as loss and isolation.

Staff have tried various means of reaching the physicians in the community, who could play a pivotal role in identifying substance abuse problems in the elderly, but have not been successful in getting their attention or referrals. It is hoped that new collaboration with the hospital systems will add a level of credibility and may capture their attention.

**Getting Started in Other Communities**

Staff’s advice on replication: “Just do it! Don’t worry about the funding!” Initial support for Elder Outreach was requested in a proposal to a local foundation but was rejected because of a perception that this was not a problem in the community. Denial can be anticipated. Because the program developers felt strongly that it was a problem, they have found other ways to proceed.

A certified alcohol and substance abuse counselor is essential to the program because of his or her knowledge of the issues. It is also important to have strong clinical leadership over the program in order to manage other issues that can exist along with substance abuse problems—for example, depression and mental illness.

Descriptive materials are available from the program.

**Keys to Success**

An element that program staff have found important is that the program does not insist on sobriety as a requirement for participation. Some reduction in drinking and improvements in self-management are acceptable for continued involvement in the program.

The staff’s holistic approach to their clients has been an effective philosophy for working with older adults. The approach used by the program allows the outreach workers to get a foot in the door, establish rapport, and learn about the person’s whole life and circumstances before attempting to deal with these issues.
Promising Practice:
Center for Older Adults and Their Families, New York, NY

Public hospital-based mental health center offers geriatric mental health services on-site and off-site through senior centers and to elders at home.

Contact
Gouverneur Department of Behavioral Health
Center for Older Adults and Their Families
Edgar Velasquez, MD
227 Madison St., #397
New York, NY 10002
Phone: 212/238-7384
Fax: 212/238-7399

Sponsoring Organization
Gouverneur Hospitals, a municipal health care facility, is part of the New York City Health and Hospitals Corporation and is affiliated with New York University’s Bellevue Medical Center. The Center for Older Adults and Their Families is the geriatric service of the Gouverneur Diagnostic and Treatment Center’s Department of Behavioral Health.

Demographics
The Center serves an extremely diverse, urban population in Manhattan. Program participants include lifelong U.S. citizens, primarily Caucasians, Hispanics, and African Americans, as well as an immigrant population from Asia, Russia, Latin America, Europe, and other areas of the world. The languages, cultures, and socioeconomic characteristics are highly variable, making cultural competency a continuing challenge.

Recognition
The program has received the highest level of certification, a 3-year award, and a commendation for its Patients Bill of Rights from the State of New York. Articles in leading professional journals (see References below) document the Center’s success. Perhaps most significant, 85 percent of patients report that Center treatment has helped them.

About the Promising Practice
The Center for Older Adults and Their Families provides comprehensive geriatric mental health services for people age 55 and older and their families. The Center uses a family-centered approach to care and emphasizes the provision of culturally competent services to a diverse population. Its program components include:

- an elder outreach team conducting home visits for assessment and engagement
- a clinic program offering assessment, evaluation, therapy, and case management
- a day treatment program with all clinical services plus activities in a therapeutic milieu
psychiatric consultation for the Gouverneur Nursing Facility

The Center serves an average of 300 clients each year.

How It Works

Outreach and Recruitment

The Center’s elder outreach program makes older adults aware of mental health services available to them and works to reduce the stigma associated with these services. The program also reaches out to elders in need. Staff go into homes, including public housing, to conduct assessments, both for those who have never had contact with mental health services and for former patients who may need to be re-engaged. Staff are available for training and education and go into the community to talk with both lay groups and professional organizations about geriatric mental health.

It was expected initially that referrals to the program would come from senior centers, but that has not been the case. Rather, referrals come mostly from primary care physicians, from in-patient psychiatric facilities, and from friends and families bringing in their loved ones for treatment. Family and friend referrals usually are appropriate, indicating the community has an accurate understanding of what the program is and whom it can help.

Services

Comprehensive mental health and substance abuse assessments are conducted by psychiatrists, social workers, psychologists, and nurses for all older adults entering the programs. Psychosocial assessments address current and past biological, psychological, and social functioning. The range of mental health problems in the client population includes depression and other affective disorders, anxiety disorders, and psychotic disorders that impede functioning.

Screening for alcohol problems is conducted using the CAGE, a questionnaire on alcohol abuse validated for use with older adults. A more detailed substance abuse assessment is provided, if indicated. Some patients are identified as dually diagnosed with both a substance abuse problem and a mental illness.

Families are included in the assessment, with special recognition of later-life families and their issues. The functioning of the family system, including its capacity to carry out the expected developmental tasks of the family with an older member is also assessed. A cultural assessment addresses issues such as immigration status and culturally rooted health beliefs.

Based on the comprehensive psychosocial assessments, treatment plans are developed that address the clients’ biological, psychological, and social functioning, including family functioning. When the Center identifies a problem it is not equipped to handle, referral is made to a community resource. For example, people with both substance abuse and mental health problems are referred to a program that offers an integrated model of care for dually diagnosed individuals. Although the Center has no licensed substance abuse treatment program, it often continues to support patients with such problems by including them in recovery and support groups.

The Center provides mental health services on-site, in a senior center, and through home visits. On-site services include day treatment, which provides a 5-hour-per-day program in a therapeutic environment offering psychotherapy and
other services. The clinic program offers single appointments for psychotherapy sessions. It was added so psychotherapy could be offered to clients for whom the day program is not appropriate, or who are not comfortable with such an approach.

Services provided by the multiethnic are available in English, Spanish, Mandarin, Cantonese, Portuguese, and Slovak. Innovative multicultural service delivery methods are encouraged—for example, bilingual and trilingual groups. The weekly community meeting of all clients and staff in the adult day treatment program is conducted in three languages. On a rotating basis, each language is the primary language and the meeting is translated for the other two. The result has increased patient participation in the meetings.

The program’s senior center services are provided by a single on-site staff member who conducts assessments, provides counseling, and offers community education. These services are in such demand that, if funding were available, a full-time person could be fully occupied. The current staff person has a master’s degree in psychiatric rehabilitation and prior experience and training in geriatrics. She is bilingual and bicultural. The senior center program is called the Grand Coalition of Seniors at Grand Street. There are several such demonstration projects—at least one in each of the five boroughs of New York City.

The senior center’s approach to care is ecological, emphasizing the older adult’s capacity to function within his or her own social system. Efforts are directed to improving not only the individual’s well-being, but also functioning within the family, the community, and health systems.

Monitoring and Reassessment
When patients have been treated successfully in this program, the next step may be to rely on the support of other community programs, including senior centers. The Center maintains good relations with senior programs. Therefore, after a brief period of formal follow-up, informal contact or re-referral is simple. However, medical illness or nursing home placement ultimately preclude their continuance in the Center.

Linkages
The Center works closely with community agencies and is a participating member of local provider and consumer advocacy groups, including the Inter-Agency Council of the New York City Department of Aging and the Manhattan Geriatrics Committee. It also is closely linked with acute care hospitals and community aging and social services agencies. Most of these relationships are documented in writing and strengthened through staff collaboration. These relationships foster referrals into the program and out to other community services and also supplement program resources.

Program Assessment
The program is licensed, certified, and monitored by the State. It is also reviewed by the New York City Department of Mental Health.

Patient satisfaction survey data reveal that patients overwhelmingly (85 percent of respondents) state that the Center’s treatment has helped them. In particular, patients clearly specify (75 percent) that “the psychotherapy services offered by the program are helpful to them.” The Center also tracks changes in health habits, and it is reviewing how it might measure outcomes. Recently, the Center has begun administering the Brief
Symptom Inventory, using it at pretreatment and every 6 months for follow-up.  

**Resources and Funding**

Sources of support are numerous. They include Medicare and Medicaid; a community support systems grant that covers some of the costs of the clinic and day treatment programs; funding from Gouverneur; funding from the New York City Department of Mental Health; demonstration grants; and private pay (funding from non-public sources such as third party insurance and appropriate co-pays and co-insurance). Remaining funding is provided by New York’s Health and Hospitals Corporation, the second largest public health care system in the world.

In addition, support for the Elder Outreach program comes from State reinvestment funds—money saved by the State when its large inpatient psychiatric facilities were closed and their patients were channeled to the local level. Medicaid covers part of the cost of services and also pays for some transportation costs. Gouverneur supports some of the transportation costs—vehicles and drivers—needed by patients who travel from well beyond the normal catchment area boundaries.

The Center partners with Hunter College to train social work students in geriatrics through funding from the Hartford Foundation, with a strong emphasis on including minority clinicians. This partnership further expands the program’s resources.

The program can provide additional information on its resources and funding.

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3 This tool is available in English and Spanish. It was developed by Leonard R. Dergatis, Ph.D., in 1975; it has been published and distributed by National Computer Systems since 1993.

**Getting Started in New York**

The senior center project began after the citywide geriatrics committee of the New York City Federation for Mental Health, Mental Retardation, and Alcoholism Services identified the need to make mental health services available in natural settings, such as senior centers. The City’s Departments of Mental Health, Mental Retardation, and Alcoholism Services worked together, with help from the New York University School of Social Work and others, to assess the feasibility of providing these services on-site. Now that the center is in place, it is considered a very successful demonstration of the value of providing these services in such a setting. The services are provided through existing resources.

The Federal Community Mental Health Centers Act of 1965 prompted development of many outpatient centers across the Nation. This program grew out of that movement and was established in 1974. It was not licensed at first; it began as a socialization program with a psychiatric component, using borrowed social work staff. Eventually, it was enhanced and licensed as a day treatment program, and then it added a clinic program. Although the Federal mandate required a geriatric service component, such services are not found in abundance in New York or elsewhere. This program is located on the Lower East Side of Manhattan. There is a second geriatric mental health program on the Upper West Side, and a third in Harlem.

**Getting Started in Other Communities**

This practice demonstrates that community aging services can collaborate with behavioral health services and psychiatric
hospitals to reach out to isolated elders to meet their mental health needs, both in the natural setting of a person’s home and in senior centers.

These services can be offered in a culturally appropriate manner. The keys are the use of natural settings and a true understanding of a culture, well beyond communicating in the same language. Though the need for a common language between patient and clinician is clear in a therapeutic environment, identifying and recruiting professionals with those languages can be a challenge. In the meantime, accommodations such as the use of interpreters can fill the gap.

Developing the clinical team as a multicultural organization in which all staff strive to be knowledgeable of other cultures and to support them enhances and supports clinicians who treat patients from diverse cultural backgrounds.

Staffing requirements may vary from State to State; generally States regulate staffing of mental health programs if third-party billing is involved. In general, however, it is essential to have at least one half-time psychiatrist, professional social workers, and a psychiatric rehabilitation counselor or Ph.D. psychologist. Transportation is essential. Nurses and activity aides enrich the program as well.

Materials and articles developed and used by Gouverneur staff are available to aid other programs, including a descriptive brochure, the family evaluation (including a Genogram), the cultural assessment (brief and extended), the substance abuse evaluation (brief and extended), and the treatment plan review. The substance abuse evaluation includes questions about substance consumption and is validated for use with the elderly.

**Keys to Success**
The Gouverneur program has identified the following as keys to the program’s success:

- true cultural competence and multicultural organizational development
- consumer empowerment
- community education and outreach
- use of natural settings

Cultural competence is a primary distinguishing feature of this program, which uses a staff with a wide array of cultures and languages to serve patients. Keys to competence are the cultural evaluation that is part of intake, the use of multicultural groups, and the use of a rotating primary language for day treatment community meetings. The rotating language practice has resulted in greater equality among the language groups, with no one language being perceived as dominant. It has also created a deeper understanding of each culture, beyond mere linguistics.

Consumer empowerment is fostered through the active participation of clients as members of the patient satisfaction committee.

**References**


Promising Practice:

Older Adult Outreach and Education Service, Ann Arbor, MI

Substance abuse treatment center collaborates with a geriatric clinic and a neighborhood services agency to provide outreach and comprehensive connected services.

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Older Adult Outreach and Education Service
Chelsea Community Hospital
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Ann Arbor, MI 48103
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Fax: 734/665-6487
email: jsmith@cch.org

Sponsoring Organization
Chelsea Community Hospital operates a substance abuse outpatient treatment program, the Older Adult Recovery Center, and an outreach program, the Older Adult Outreach and Education Service. This service, in place since 1995, is conducted in close collaboration with the University of Michigan Turner Geriatric Clinic and with Neighborhood Senior Services, a non-profit social services agency dedicated to outreach and support for seniors living in the community.

Demographics
Ann Arbor, a city of about 110,000, is relatively prosperous and has a growing population of older adults. It has been voted one of the top five retirement communities in the United States in two national surveys. It is home to the University of Michigan and the high-tech and cultural center of Southeastern Michigan.

Recognition
The Older Adult Outreach and Education Service received a local collaboration award in 1998. It has been featured in stories by the Associated Press, the Detroit Free Press, the Ann Arbor News, ABC’s Prime Time Live, the 700 Club, and local news programs. Stories have also been carried on local affiliates of Fox and NBC. The service was also featured in a syndicated news story shown on more than 300 stations nationally in June 2000.

About the Promising Practice
Through various linkages, the Older Adult Outreach and Education Service provides inpatient and outpatient substance abuse and mental health treatment, counseling, and aggressive outreach. Its collaborating agencies are its sponsor, Chelsea Community Hospital, with its treatment facility, the Older Adult Recovery Center; the University of Michigan.
Turner Geriatric Clinic; and Neighborhood Senior Services. The program has successfully integrated services provided by the collaborating agencies, delivering non-overlapping resource assistance to older individuals. The agencies are able to refer clients seamlessly and with a minimum of red tape.

**How It Works**

This hospital-based substance abuse treatment program trains its partners and providers of services for the aging to recognize potential substance abuse and mental health issues among the older adults they serve. Outreach services are provided for individuals unable or unwilling to accept a referral to substance abuse or mental health services.

The geriatric clinic, the neighborhood services agency, and other aging services call on the Older Adult Outreach and Education Service to meet in the homes of older people who may need substance abuse services. Numerous visits often are required before an individual is ready to accept substance abuse treatment. The Outreach and Education Service also collaborates closely with its partners to ensure that other needs of elders they serve are addressed.

Once individuals are in contact with any of the collaborating organizations, they have ready access to all services offered by the collaborators, including inpatient or outpatient treatment for substance abuse and mental health concerns, geriatric medical care, and services of the University of Michigan health system. Individuals also have access to the neighborhood services agency and its social workers, who link elders to appropriate resources for any needs they identify.

These needs range from home safety assessments and installation of safety equipment or assistive technology to help in securing entitlements.

Clinical supervision for the collaboration is provided through Chelsea Community Hospital’s Older Adult Recovery Center. All persons involved in the collaboration have been trained in matters of cultural competence. Where appropriate, referrals are made to specialized therapists, resources, and other organizations for further support and assistance.

**Outreach and Recruitment**

The Older Adult Recovery Center sponsors “The OARC Players,” a group of elders who earlier received substance abuse treatment and today perform vignettes about senior chemical dependency for professionals and peers. They offer monthly performances providing education to senior centers, nursing homes, social and religious groups, and professional conferences. The skits demonstrate techniques for talking with older adults about substance abuse and sometimes include volunteers’ personal stories.

With this collaboration in place, the geriatric clinic and neighborhood service agency make the most referrals to the Older Adult Recovery Center. In addition, referrals come from the following sources (in order of frequency):

- family members (usually a daughter or daughter-in-law)
- physicians, home care aides, or other health care workers
- the legal system
- other social service agencies
Reaching physicians is an ongoing challenge. The Outreach and Education Program was unable to attract many physicians to a training session that offered continuing education credits. The program now focuses on educating physicians and their staffs in the medical offices. When a physician refers a patient for substance abuse evaluation of treatment, program staff visit the doctor’s office and update him or her on the patient’s progress.

Services
In addition to outreach, Chelsea Community Hospital offers inpatient, outpatient, day treatment, family therapy, and group psycho-educational services. The treatment program is a full-spectrum, intensive chemical dependency treatment program, offered since 1986. Older adults in recovery who have completed the treatment program are an integral part of treatment services. They participate as peers in therapy groups and aid in outreach calls. These elders may use other resources in the community for ongoing support.

The Turner Geriatric Center has provided comprehensive geriatric care, health promotion, learning programs, and community resource information for more than 20 years. Turner also runs support groups for seniors on a variety of issues and concerns, writing groups, computer literacy classes, and continuing education presentations.

Neighborhood Senior Services started as a grassroots organization serving a single neighborhood in Ann Arbor and has grown to serve the senior population of the entire county with a broad array of services, including home-chore assistance, transportation, volunteer services, and resource advocacy (case management and entitlement assistance).

Linkages
As noted, the partners of Chelsea Community Hospital, the sponsoring group, are the Turner Geriatric Clinic and Neighborhood Senior Services. These three partners do not operate in a vacuum. Local mental health resources, transportation, food banks, Meals-on-Wheels, apartment complexes, Section 8 housing providers, the Family Independence Agency (a social welfare agency), and other nongovernmental social services providers, along with legal resources and charitable organizations, are all involved at various levels with clients, especially through the outreach component.

Recently the director of the Older Adult Recovery Center testified on issues of older adults and substance abuse in a hearing held by the area agency on aging. As a result, he was to begin training the agency’s case managers on the identification of problems in older adults and effective techniques for motivating them to seek treatment. Part of this effort involves teaching them to integrate questions from the Michigan Alcohol Screening Test–Geriatric Version (MAST-G) into their interviews. He hopes to strengthen his ties to both the area agency on aging and the adult protective services agency. Both Turner and Neighborhood Senior Services receive funding from the area agency on aging, and that linkage has served to connect the substance abuse and aging fields.

Program Assessment
Outcomes measured are primarily service-related. The Older Adult Outreach and Education Service measures its success in the productive connections made between
older people and the services they need. Numbers of older people receiving needed new services indicate success. Results are documented in quarterly reports, including demographic data on race, ethnicity, gender, age, income, disability status, and locale. The State agency provides evaluation and monitoring and prepares semiannual reports. The community hospital is licensed and accredited by the State and accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

**Resources and Funding**

The outreach effort is funded by the State with block grant funds received from the Substance Abuse and Mental Health Services Administration (SAMHSA). Treatment services are paid for by Medicare, Medicaid, private insurance, and some State funding. The SAMHSA grant is exclusively used for outreach, predicated on the assumption that the Older Adult Recovery Center could provide treatment.

It should be noted that Turner has a resource not found in every clinic—a master’s level social worker trained in pre-treatment counseling. Pre-treatment counseling involves working with individuals to explore their motivation for seeking treatment and encouraging them to proceed, and providing harm-reduction counseling for individuals who are not yet ready to seek further treatment. Because referral to a medical clinic carries less stigma than referral to a mental health center, this is often the crucial contact in preparing the individual for the “real” referral.

The program can provide additional information about its resources and funding.

**Getting Started in Ann Arbor**

The community hospital initiated this collaborative outreach and education effort because, as its founder put it, “You can’t do anything in substance abuse for older adults without an outreach component.” Staff at both the geriatric clinic and the neighborhood services agency were aware of the problem but did not know what to do. The neighborhood services agency, for example, would repeatedly be called to deal with cleaning up an apartment—but not to address the underlying problem of substance abuse.

The Older Adult Outreach and Education Service has a half-time staff person with substance abuse experience who offers training and education.

The program has evolved, based on developments in the field of older adult treatment and client response and reaction. Today, it educates older adults on risks of medication and alcohol-related problems and focuses on helping those with problem drinking or other substance use to reduce their consumption to a “safe” or appropriate level. An abstinence model (that encourages total abstinence) is used for people who are dependent on alcohol and other mood-altering substances.

A key factor in the program’s success is staff persistence. Many staff members were frustrated initially because they expected a standard intervention built around immediate confrontation with an individual to be sufficient. It was not. Instead, experience has shown a consistent presence is necessary. It may take 6 months to a year to find a “teachable moment” when the individual is amenable to treatment or when the family is ready to encourage the elder to seek treatment. This often involves a crisis or an accident, when the family is called in and forced to confront the problem.
**Getting Started in Other Communities**

It is possible to replicate this effort with strong partners and start-up funding to support the costs of outreach workers’ time and training. As noted, there is expansion planned—principals hope to expand geographically to a second geriatric clinic and two senior housing units. A research component will be part of the new project, comparing effectiveness of referrals to direct service delivery.

Limited materials are available from the program.

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**Keys to Success**

Outreach is the key to serving older adults. It is essential to reach those individuals in the aging community who are resistant to recognizing the problem. Other keys to success are the linkages to the other critical partners and the availability of outstanding resources in the community.
Promising Practice:
Adair Elder Care, Adair County, KY

Community mental health center, in a joint venture with a fiscal court and an area agency on aging, operates an adult day health program addressing substance abuse and mental health needs of elders.

Contact
Dr. Lynda Wilkerson
Adair Elder Care
127 N. Reed St.
Columbia, KY 42728
Phone: 270/384-5351
Fax: 270/384-6971

Sponsoring Organization
Adanta, the regional mental health authority, operates the community mental health center that established this adult day health program. The authority serves the same 10-county area as the local area agency on aging.

Demographics
Adair County, Kentucky, which is served by this program, has a population of 16,447, of whom 2,573 are 65 and older. Educational attainment is low; the poverty rate is high. At one time, families were primarily engaged in subsistence farming. The garment industry was a major employer for a few decades. Its demise left behind many elders with limited resources. A compounding factor is that many middle-aged women who had been caring for their elderly relatives moved away when they lost their jobs in the garment trade.

Recognition
The Center was recognized as the 1994 Center of the Year by the Kentucky Adult Day Services Association. It has been featured twice in the elders section of the local newspaper, and its many special events have received press coverage. The program enjoys broad community support and has earned the loyalty of county political leaders.

About the Promising Practice
The Adair Elder Care program is a joint venture of the Adair fiscal court, the financial arm of the county government; the community mental health center; and the area agency on aging. It is the only adult day health center in the State operated by a mental health agency. The Center serves older adults with substance abuse and mental health needs, providing counseling and support groups, and ensuring that appointments are kept.

The mission of this “medical model” adult day program is to provide cost-effective adult care and a variety of support services that improve the quality of life for older and dependent adults who choose to remain in the community.
Sixty percent of the clients served have substance abuse or mental health issues, 30 percent are physically frail, and 10 percent have developmental disabilities. Many of the clients with chronic mental illness coped successfully with their problems for years but now face new issues that they cannot manage alone. Others, including those with alcohol and substance abuse problems, may have hidden their conditions for years only to have them exposed with the death of a spouse or another change in living conditions.

How It Works

Outreach and Recruitment
In this small community, most residents are known, and referrals often come from neighbors.

Assessment and Service Plan
An interdisciplinary team conducts the assessment and develops the plan. Included are a nurse, a social worker, a recreation therapist, certified nursing assistants, master’s level students, and a psychiatrist, if necessary. In addition, the client or a client’s representative participates fully in the development and implementation of the individualized plan of care.

Services
Adair provides services 6 days a week, 6 hours a day in a facility that can accept up to 45 participants. The services include assistance with daily activities, nursing services, stimulating and therapeutic activities, personal care, advocacy services, and meals (breakfast, lunch, and snack).

Both individual and group counseling are offered at the center. Direct referrals can be made to the hospital. Linkage agreements exist with the local hospitals, self-help groups, nursing homes, rehabilitation programs, and physicians.

Services are available for caregivers as well. If staff are aware of a potential problem, they will conduct an assessment and referral to service. If necessary, they may accompany the caregiver and support efforts to resolve the problem—for example, arranging for respite care. There are also caregiver support groups.

Clients served in the program are frail elderly or individuals with developmental disabilities. Preference is given to those with mental health or substance abuse problems. An individual’s potential to benefit from the program also is considered. Many of those referred do not meet all of the criteria, and efforts are made to link them with other appropriate services.

Monitoring and Reassessment
Quality of life issues are assessed at intake, at 6 months, and at the end of one year. Outcomes considered include changes in nutritional status for those with alcohol issues and decreased hospitalizations. The program has demonstrated a decrease in hospitalization among its participants.
**Linkages**

Beyond the linkages that created the Center, active collaboration has been developed with the State housing authority, including a volunteer program that provides home repairs for elders. The health department sends staff for screenings as well as seminars. The Center and the health department recently collaborated on a grant proposal for breast cancer screenings for middle-aged and older women.

There is also a Triad program in which Adair staff work with seniors, State police, sheriffs’ association, and local police council to address crimes against the elderly and to make seniors more aware of potential threats.

Linkages also exist with the area agency on aging. For example, the area agency covers the cost of care for many clients and the director serves on the Triad board.

Alcoholics Anonymous meets next door, and Al-Anon meets in the center one evening a week. There is ongoing collaboration with the senior center. Informal linkages take place through the involvement of the director in the community. The director serves on many boards in the community and otherwise actively cultivates partnerships.

This community offers a full continuum of care, and this center is an important part of the network.

**Resources and Funding**

Staff include a geropsychiatrist, available when needed and on-site 4 hours a month, as well as two RNs, both psychiatric nurses with backgrounds in geriatrics. In addition, there are contracts with five universities for placements for social workers, nurses, and human services professionals. Each semester there is at least one master’s-level student and two at the bachelor’s level. Although one university is close by, two of the five are 100 miles away.

As noted, the Center itself was the product of collaboration. The fiscal court provided the funding to save the site; it holds the deed, and it is paid $1 each year for rent. Additional funding comes from the county and the city, donations from community groups, and revenue-generating activities.

The program fee is kept at $20 for a less than 6-hour day so that no one need be turned away. Scholarships, sponsorships, and grants also are available. Some patients receive reimbursement through a Medicaid waiver, though it covers only 80 percent of the cost and the State is considering a substantial reduction in the rate. There is no Medicare reimbursement and no private insurance.

The program can provide additional information on its resources and funding.

**Getting Started in Columbia**

This center started 9 years ago when the Adair Fiscal Court and Adanta joined together to reclaim the old county health department building and to make it into “the place” for older adults in the area. Their goal was to create a resource to meet a wide range of needs for older adults, including those with alcohol and substance abuse problems. A separate board was established to oversee the
Center; it includes representatives of the hospital, clergy, mayor’s office, caregivers, consumers, and elders. In the first 3 years of the program the board served as advisers and designed the services that would be offered, including caregiver support.

**Getting Started in Other Communities**
The program already has been replicated in an additional site and is currently being replicated in three others, all in Kentucky. A limited number of materials, including a training manual, are available from the center.

The staffing ratio at Adair is an unusually high 1:2. A minimal ratio for replication is 1:5, a rate that is still higher than in many adult day centers. Essential staffing considerations include background, training, and experience in both geriatrics and mental health or substance abuse.

**Keys to Success**
Public support, active efforts to keep the program in the public eye, and commitment on the part of local elected officials have been essential to program success. One county commissioner, in particular, has been very supportive of the program. To that end, center staff have participated in community activities designed to build support, such as health fairs, caregiver support groups, and community forums.

Staff have extensive training and an excellent retention rate.
Section 5  

Service Improvement Through Coalitions and Teams

Introduction

Many service providers have increased their capacity to help older adults by building coalitions and teams to coordinate and improve services. Today, many area agencies on aging and senior centers include education, prevention of medication and alcohol-related problems, and mental health services. They develop working relationships with local specialists to help train staff, educate older people, and refer individuals in need of treatment and special services.

Aging services leaders, along with mental health and substance abuse service providers, may conclude that the services available in the community are inadequate to address the full range of needs among older adults in the area. The services may not be available or affordable to those in need. Throughout the country, the aging network is working with the substance abuse and mental health communities to meet this challenge by creating coalitions to define the needs of older adults and expand the existing base of services.

Promising Practices in Service Improvement Through Coalitions and Teams

Several of the promising practices reviewed in this section created coalitions or teams in response to an identified weakness in the service arena. State and local coalitions addressing mental health, substance abuse, and aging are now being developed in many States and localities across the country. They involve joint task forces or workgroups with clear accomplishments at the State level; most of them have also identified local, county, or regional activities as part of the overall effort.

These practices are models of collaboration. They focus on public education, cross-training, case coordination, and systems planning. They can be implemented under a variety of auspices, most readily through local government, or in a voluntary collaborative atmosphere when the community has a history of such an approach.
One of the practices links mental health, aging, and substance networks through cross-training. This practice has managed to operate in a complex environment—a tri-State area with varying laws, authorities, and funding streams.

A common element in the practices profiled here is the placement of the older adult at the center of the delivery system. Rather than focusing on specific services or agencies, they focus on the client—and systems are designed to respond to the client’s needs.

**Implications for the Aging Network**

Coalitions, at both the State and local levels, offer an ideal opportunity for the aging network to fulfill its advocacy role as envisioned in the Older Americans Act and in the evolution of the network. The most significant implication for the aging network is that local, service-centered coalitions create an opportunity to enhance service capacity dramatically.

**Resources**

Many of these programs, as noted in their profiles, are prepared to make materials available to guide the development of similar programs elsewhere. For example, the curriculum design used by the Ohio-Indiana-Kentucky Coalition for cross-training is a good resource for similar activities. The extensive materials of the Wrap-Around Program Team (Concord, NH)—including the report card—are available through that program and soon will be available online.

SAMHSA’s Center for Mental Health Services has worked closely with the AARP Foundation to support the development of State and local coalitions on mental health and aging. Materials developed by the AARP Foundation on building aging, mental health, substance abuse, and primary care coalitions are available from the American Psychological Association, Office on Aging (202/336-6046).
Promising Practice:

Alcohol and Drug Services—Prevention for the Elderly,
Fairfax County, VA

County government supports a comprehensive array of alcohol and drug prevention services through interagency collaboration.

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Alcohol and Drug Services—Prevention for the Elderly Program
County of Fairfax
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Fairfax, VA 22030-4013
Phone: 703/934-8772
Fax: 703/934-8742
web site: www.co.fairfax.va.us/service/csb/ads/adsmain.htm

Sponsoring Organization
The Prevention for the Elderly program is sponsored by the Fairfax-Falls Church, VA, Community Services Board/Alcohol and Drug Services. The Fairfax-Falls Church Community Services Board is part of the Fairfax County Human Services system.

Demographics
Fairfax County frequently is cited as having the highest per capita income in the nation. With a population of nearly one million, it is the largest and wealthiest jurisdiction in the Washington, DC, area. Its population is relatively young—fewer than 9 percent of the people are over 65—and increasingly diverse: 13 percent Asian, 9 percent Hispanic, 8 percent African American. Education levels are high; 56 percent hold college degrees. Yet significant numbers of citizens need housing, financial assistance, health care, and human services. Historically, the county government has been very responsive to these needs, and it offers a rich array of services.

Recognition
The program has received awards, certificates of appreciation, and letters of commendation from the regional Council of Governments (1993), the Fairfax County Commission on Aging (1995), the United Way (1996), and the program’s sponsoring agency (1997).

About the Promising Practice
In a rapidly growing region dominated by relatively affluent younger persons, it can be difficult to muster the resources to combat substance abuse and mental health problems in the aging. The Alcohol and Drug Services’ Prevention for the Elderly program utilizes a tightly integrated program of interagency cooperation and collaboration to raise public awareness, educate professionals, and conduct prevention and outreach programs throughout the country.
How It Works

The Alcohol and Drug Services’ Prevention for the Elderly program intentionally builds interagency collaboration through a range of activities in the following areas:

- **Community Networking**—facilitating identification of older adults who should be encouraged to accept substance abuse and mental health treatment

- **Case Consultations**—offered by phone, on staffing teams, and in person

- **Prevention and Outreach**—using home visits and phone calls to reach older adults who are thought to be candidates for screening

- **Education and Training**—including a six session Wellness Discussion Series for Seniors and training for human service professionals to raise awareness of substance abuse and mental health issues and provide information about community resources

The Prevention for the Elderly program’s community networking, case consultation, and prevention and outreach activities are managed through weekly geriatric team meetings and monthly interdisciplinary team meetings that address a broad range of needs and services, including alcohol and drug abuse.

The program’s primary activities focus on prevention, extending the team’s messages regarding alcohol and medication misuse and abuse through:

- booths/exhibits at senior fairs and the county fair
- distribution of public information materials
- sponsorship of a substance abuse awareness campaign involving as many as 15 to 20 workshops a month
- promotion of Older Americans Month in May to build public awareness

Alcohol and Drug Services recently worked with the area agency on aging to increase awareness through a cover story on substance abuse in the area agency’s publication that has a circulation of 40,000. The program also mailed information to 250 physicians, alerting them to the types of lab results that might require further investigation and suggesting ways to approach older adults about potential alcohol and medication misuse and abuse. This was modeled after a similar program in Oregon.

Alcohol and Drug Services also takes part in a Triad group, a regional organization including the sheriff, chiefs of police, and representatives of all the towns and cities as well as the county itself. The group meets to address crime issues. It is particularly relevant because older adults who abuse alcohol or drugs are more susceptible to harm or exploitation.

Since 1991, the program has sponsored a series of wellness discussions in senior centers throughout the county. These sessions have become a major element in raising awareness. Sessions are offered once a month, with about six centers covered in a calendar year. In this way, each center is covered roughly every 2 to 3 years. Alcohol and medications are addressed in all of the sessions. Topics include “Wise Use of Medications,” “How to Talk to Your Doctor,” “Habits Over a Lifetime,” “Stress and Retirement,” and “Emotions and What to Do with Them.” The series includes a workshop that addresses alcohol more directly, usually titled “When One Drink
Is Too Many.” This discussion covers such topics as “How to Talk with and Help Someone with a Problem” and “How Alcohol Affects Others.”

Training about older adults and substance abuse is offered at least every other year to the staff of other county agencies, including the area agency on aging; the Health Department; the Department of Family Services; Adult Protective Services; and the staff of Geriatric Mental Health, the senior centers, and the Housing Department. Offering the training on a regular basis helps expose new staff to the issues.

The program director cites a need for additional mental health outreach and low-cost treatment options. This view is reinforced, perhaps, by the finding in the most recent county needs assessment: 63,000 residents (19 percent of the population) responded that a family member has a substance abuse or mental health problem.

**Services**

Clients are brought into care through the following process:

- A call is made to the county Information Line (the starting point for all county residents regardless of age and type of need), where it is screened.
- If the caller is an older adult, he or she is referred to the area agency on aging, the Recreation Department, or the geriatric team.
- A nurse conducts an outreach visit.
- The nurse brings the case to a team meeting.
- If substance abuse seems to be an issue, staff make an outreach visit.

Access to treatment is described as difficult because only one program in the county specializes in older adults. Most programs are geared to younger people and focus primarily on the abuse of cocaine, heroin, and marijuana. Some therapists have an interest in older adults, but programs tend to be expensive, and residential programs require individuals to be able to care for themselves. Only one hospital accepts Medicare for detoxification. If the patient is admitted for another problem, detox might be covered as a secondary need.

Program outreach results in screenings and referrals, but the volume continues to be relatively low. Clients identified through the home outreach program usually are in late stages of a major problem and often need to use Adult Protective Services.

**Monitoring and Reassessment**

Individual care planning sessions, as well as sessions focused on specific challenges presented by an individual client to an agency, take place at weekly 2-hour meetings of 12 to 15 professionals. This geriatric team, also known as Care Network, includes nurses, social workers, and mental health professionals. Monthly meetings of an interdisciplinary team take place as well. Cases may come to the team because of requests for services such as chore or in-home care that then lead to the identification of a need for substance abuse or mental health services.

Confidentiality is an important concern to the program. The geriatric team protects confidentiality through use of a consent form that is part of Virginia’s universal assessment tool for all public programs. The interdisciplinary team does not use names.
Linkages
A wide range of agency representatives participate in weekly geriatric team staffing as well as in monthly interdisciplinary teams. The agencies involved include the area agency on aging, Mental Health Services (the Community Services Board), the Department of Family Services, Adult Protective Services, the Community and Recreation Department (for senior centers), the Department of Housing and Community Development, the Health Department, and others as needed.

Program Assessment
Program evaluations are undertaken annually. Data also are collected through the State’s assessment instrument, and feedback is solicited from older people and their families and from the various agencies involved.

Documented numbers of participants and results are available for the past 2 years. An evaluation is completed at the end of each wellness discussion. Feedback almost always says that the presentation was on target. In fiscal year 1999, of the 1,277 seniors participating in the wellness discussion series, 100 percent said that they benefited from the series, that they learned new concepts, and that the presenter was well prepared.

The senior center directors also evaluate the sessions. It was their feedback that prompted the addition of two of the six sessions, namely those dealing with emotions and stress. They have also recommended a session on grief.

In fiscal year 1999, 409 service provider consultations were provided through geriatric team staffing. Twenty-four older adults were screened for substance abuse or mental health outreach; of those, 18 were referred to treatment or other services. Six interventions were completed, and four individuals went on to treatment.

Transportation is a serious issue in this large, 399-square-mile county. The county’s large size and its severe traffic congestion create time and travel difficulties for both older persons and county staff. The situation is especially severe in the case of home care workers who also are difficult to recruit and retain.

Resources and Funding
This initiative, begun with grant funding in 1993–94, is based on the foundation of case management services for those age 60 and older who are eligible for nursing home care. It continues to operate primarily with county funding, coupled with some funding from the Older Americans Act. Clients are encouraged to use Medicare benefits or apply for Medicaid when appropriate. Additional funding comes from the Federal Substance Abuse Prevention and Treatment Block Grant to the State.

Fairfax County has one position allocated for this program. The program would not be as successful as it is without the Care Network, which includes two nurses, a mental health specialist, four social workers, and a supervisor. Those positions are funded by the Department of Family Services.

The program can provide additional information on resources and funding.
Getting Started in Fairfax
The position of Substance Abuse Counselor II, functioning as a prevention specialist, was created in Fairfax County in 1991. In 1989–90, the Virginia General Assembly had become concerned about the high rate of elderly suicides in the State and encouraged local areas to begin to examine both suicides and alcohol abuse. It encouraged the use of Substance Abuse Prevention and Treatment Block Grant funds for addiction prevention programs; Alcohol and Drug Services continues to operate with these block grant funds. The trainer program and materials were developed through Virginia Commonwealth University.

Alcohol and Drug Services’ Prevention for the Elderly program began in Fairfax in 1993 with a 5-year grant from the State. Three demonstration sites existed in the State: a rural area, a city, and this county with its mix of urban, suburban, and rural areas. The key question was, what is the best way to serve constituents?

Getting Started in Other Communities
Portions of the program are easy and inexpensive to replicate. One example is the wellness discussions—especially if presenters are prepared through a “train the trainer” approach (preparation of a cadre of trainers who are prepared to a standard curriculum in a consistent format to train a significant number of students). Establishing geriatric teams is more difficult, since agencies must be willing to commit staff for significant amounts of time.

Primary materials are available from other sources, in particular those produced by Virginia Commonwealth University and the Hazelden Foundation. The Virginia Universal Assessment form is used for referrals, screening, and tracking.

Keys to Success
Keys include a responsive local government and agencies that are both committed and open to collaboration. The geriatric team demonstrates cultural competence by communicating fully in Spanish as well as English and also works with other cultures—collaborating, for example, with the Korean Community Center and with the Center for Multicultural Services, a nonprofit organization through which interpreters for any language can be contracted.
Promising Practice:

Elders Wrap-Around Team, Concord, NH

Wrap-around team from more than 12 agencies ensures that no elders in need fall through the cracks.

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web site: www.riverbendcmhc.org

Sponsoring Organization
Riverbend Community Mental Health Center is the parent organization for Riverbend Elder Services, which is the lead agency for the Elders Wrap-Around Team. Riverbend Community Mental Health Center is over 25 years old, with a staff of 270. It served more than 6,000 people in 1999 with outpatient and emergency services, crisis stabilization, children's services, and three satellites.

Riverbend Elder Services has been in place since 1993. With a staff of 11, it serves more than 430 people, offering 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; community outreach; and consumer advocacy. This program has a clear commitment to developing and building collaborative relationships.

Demographics
The target population is adults age 60 and older. Concord is an urban area with an elderly population of 12 percent. The area is doing well economically and continues to develop services creatively.

Recognition
In spring 2000, the Riverbend Elder Services program received an award from the National Council for Community Behavioral Health Care for Special Programs—Older Adults for its leadership in creating the Elders Wrap-Around Team. In addition, the parent organization, the Riverbend Community Mental Health Center, received the Behavioral Healthcare Leadership Award from Eli Lilly and Co. and the Year 2000 Effective, Efficient Provider Organization award from the National Council for Community Behavioral Health, also in spring 2000.
About the Promising Practice

Because of the complex needs of older adults, many Riverbend clients are involved with more than one community agency. This can cause confusion and duplication of services. It also can lead to the dangerous assumption that another organization is taking care of a particular problem.

The Elders Wrap-Around Team provides coordination of services to ensure that no elder slips through the cracks.

How It Works

The Elders Wrap-Around Team includes representatives of 12 core agencies who meet for two hours each month to review specific cases and discuss community issues. Professionals from another 40 agencies are invited to join the group, when appropriate. Consumers and families also are invited to participate. Other activities include family education and support, and community educational programs for elders and staff of service organizations.

The wrap-around intervention is community-based, cuts through traditional agency boundaries, and is centered on the strengths, needs, and desires of the older person and family. It supports independence as long as possible and includes the delivery of individualized services in three or more domains of an elder’s life. It is not a service but a process that provides care and safety by “wrapping services around” the individual.

Referrals to the team may be anonymous or may take the form of the more traditional client referral. An anonymous referral often stimulates a brainstorming session that looks at direction rather than solution. Because names are not used, confidentiality remains intact. The second type requires both a client information form and a consent form. The consent form indicates the agencies and persons involved in the case. The client and family are made aware that confidentiality is maintained by all involved. The decision about how to provide treatment is made by the team as a whole, giving priority to the most prominent need.

Services

Team services include education, training, screening, and treatment.

- **Education** is provided through workshops, presentations, and educational opportunities targeted to a wide audience, including consumers, families, caregivers, students, and professionals.
- **Training** is offered to nursing staff, students, and other professionals in the community. It encompasses the physical, emotional, and social aspects of elder care.
- **Screening** is offered throughout Merrimack County and includes depression screening, memory loss clinics, social anxiety screening, and substance abuse screening. Referral comes from physicians, hospitals, police, retirement communities, families, and any of the agencies involved in the wrap-around process. If screening indicates further evaluation is warranted, a letter is sent, with the individual’s permission, to the primary care physician.
- **Treatment** can be agency-specific or a collaborative effort of the Wrap-Around Team. The team, family, and client work together to develop a treatment plan.
Because of the stigma associated with mental illness, elders often are reluctant to seek treatment. The wrap-around process helps minimize stigma, because the Elders Wrap-Around Team (rather than the Community Mental Health Center) is identified as the entity with whom the client will be working.

**Monitoring/Reassessment**
Substance abuse and mental health status are assessed, whenever indicated. Raising awareness of these issues among all of the agencies and their staffs is an ongoing activity.

**Program Assessment**
Early data show that hospital admissions declined, as did length of stay. Total referrals to other community services increased significantly. An increase in team members from 12 to more than 50 appears to be a good indication of the commitment to the process by community agencies.

The program recently completed its first year and a half and has served approximately 18 consumers. Staff report that the informal brainstorming and anonymous referrals have been significant. The program has been tested with several provider groups with positive results.

**Linkages**
The program involves 52 agencies, including the Department of Elderly and Adult Services; providers of health care, human services, housing, and transportation; police; the public guardian; a long-term care coordinator; senior centers; church groups; elders; families; visiting nurses; and legal and financial providers. Additional agencies are involved on a client-specific basis.

The linkages among community agencies and the collaborative nature of the Wrap-Around Team effort have allowed for greater access to services for elders and their families. Many times, families have faced difficult decisions and have been unsure where to turn for assistance. This process helps to eliminate confusion and feelings of helplessness involved in finding out which services may be available to them. Additionally, the wrap-around process seeks out the gaps in the system and tries to eliminate them by finding alternative and creative means of solving problems.

**Resources and Funding**
One staff position for development and coordination of the program has been funded by the State. Adequate staff time for meetings and collaborations is required. Additional costs are minimal.

The Wrap-Around Team does not bill directly. Providers bill independently for those elements of the program that are reimbursable under Medicaid and Medicare. Informal supports and gaps in eligible services are provided through in-kind contributions, resource sharing, flexible funding, and small grants.
Getting Started in Concord

The project, developed as an expansion of existing efforts, was built on established collaborative efforts with other area providers and also on a similar wrap-around approach to serve children. Providing wrap-around services for older adults proved to be more complex, because:

- Parents, teachers, and counselors are available to assist in dealing with children
- Children seldom have major medical complications
- Older adults generally have more complex transportation and equipment needs

In the initial stage, team organizers were met with skepticism. There were turf issues and political agendas as well. Some people were concerned that Riverbend Elder Services would “own” this process. It took a lot of networking, knocking on doors, telephone conversations, and mailings to reach an understanding that Riverbend did not intend to control cases or referrals. In time, the entire team took on ownership of the process with the commitment of its members.

Initially, follow-through seemed to be a problem. Therefore, an early modification was the use of an agenda format that incorporates assignments, identification of the responsible party, and a follow-up review date. This was reinforced with the introduction of the Wrap-Around Report Card, which tracks the process.

Getting Started in Other Communities

This process can be replicated. Consultation and materials have already been provided to interested cities and towns throughout New Hampshire. Staff advises the designation of a person (at least half time) dedicated to the design and development, especially in the beginning stages where networking is a critical component. It will be important to protect that time.

Documentation is made available to the New Hampshire Department of Health and Human Services and also to others interested in developing a similar program. Extensive materials are available, including the Wrap-Around Report Card, and there have been requests to replicate the materials. These materials will soon be accessible on-line and available to all.

Keys to Success

The key is the willingness of all agencies and representatives to abide by the two rules:

- Always act in the best interest of the client
- Leave turf issues behind
Promising Practice:

Mental Health and Aging Coalition, Indiana, Kentucky, Ohio

Regional mental health and aging coalition offers cross-training in the fields of aging, mental health, and substance abuse.

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Sponsoring Organization
The two primary partner organizations for the Mental Health and Aging Coalition are the Hamilton County (OH) Community Mental Health Board and the Council on Aging of Southwestern Ohio.

Demographics
The region covered by the program includes multiple counties in Ohio, Kentucky, and Indiana. The total population served is estimated at 1.7 million, 24 percent of whom are over age 50. The region’s population is 87 percent Caucasian, 11 percent African American, and 2 percent “other.”

Recognition
Nationally, a poster presentation of the Coalition’s ElderReach project was presented by Ann Perrin of the Health Foundation of Greater Cincinnati at the annual conference of the Grantmakers in Health in spring 2000. Another presentation, by Marietta Cappelletti, Director of ElderReach, was made in October 2000 at the Grantmakers of the Aging Society’s annual conference. ElderReach was recognized locally by the Tri-Health Senior Link quarterly as a new and coming practice. It also
was recognized by a local suburban community, the Village of Woodlawn, for work with the village police department.

About the Promising Practice

The mission of this regional coalition is to promote education, advocacy, and access to behavioral health services, including both substance abuse and mental health services. It also provides support services for older adults, their families, and caregivers to enhance their quality of life. Its 42 member organizations represent the aging network, substance abuse and mental health boards, advocacy organizations, hospitals, and other providers.

The Coalition focused its first efforts on planning and cross-training, which were found to be an important means of introducing professionals from various services to one another. With a grant from the Health Foundation of Greater Cincinnati, Coalition members have developed the ElderReach project, an initiative that cross-trains professionals in all three networks in the subjects of normal aging as well as mental health and substance abuse problems in older adults. The goal is to provide training about older adults’ needs to professionals in mental health, aging, and substance abuse so they can secure appropriate help for their clients. It also provides a more effective way to address the needs of older adults by enhancing services, promoting appropriate use of those services, and creating easy access through a perceived “single system” of care. The ElderReach project is a collaboration between the Mental Health and Aging Coalition and Gateway Behavioral Health Network, a consortium of substance abuse and chemical dependency organizations.

How It Works

The Coalition’s member organizations meet monthly in a forum, enabling members to reach a large number of service providers. Through the work of three committees—on education, advocacy, and systems network—the coalition is forging ways for aging, mental health, and substance abuse networks to link together in a tri-State area.

Although many substance abuse and mental health providers are available in this geographic area, the Coalition is working through the ElderReach project to encourage these providers to address the needs of older adults. The Coalition’s ElderReach project makes four kinds of presentations for four different audiences:

- cross-training for professionals
- public education for staffs of other organizations or groups that might be in contact with individuals in need—for example, public service staff
- presentations to elected officials to secure ongoing support
- presentations to other networks—such as the Inclusion Network, which represents those who serve the elderly disabled population—to advocate integrating the networks

Services

Enhanced age-appropriate services and increased use of services are expected to result from the efforts of the ElderReach project as case managers become more familiar with resources and more comfortable with referrals. At the same time, behavioral health care providers increasingly are responsive to older adults.
Monitoring and Reassessment
The Coalition’s focus is on education, advocacy and systems networking/linkages. The Coalition does not directly assess client clinical status or monitor individual client progress.

Program Assessment
The ElderReach project uses formative and summative evaluation processes to develop clear objectives and measurable outcomes. For example, one of the five objectives is to facilitate change within the infrastructures of the organizations that participate in the Mental Health and Aging Coalition. The outcome is that 20 agencies will have implemented at least three change processes recommended by the Mental Health and Aging Coalition.

The ElderReach project continues to collect data on the training needs of professionals and in-home workers who care for older adults. In consultation with the Scripps Gerontology Center, ElderReach is evaluating the effectiveness of the cross-training provided to the professionals in the three fields. Results of the evaluation are expected in 2001.

Preliminary indicators are promising. For example, staff of the area agency on aging, formerly frustrated by encounters with clients with mental health needs, now report being better prepared to identify problems, approach clients, and make appropriate referrals. Another example is the creation of a resource manual for members. This was done by adding mental health resources to an existing manual produced by the Cincinnati Area Senior Services. The manual is now circulated to those in the mental health field as well.

Linkages
Forty-two organizations from three States are involved in the coalition and the ElderReach project and take an active part in its efforts. They represent mental health boards; alcohol and drug addiction services boards; area agencies on aging; and providers of aging, mental health, and substance abuse services. The ElderReach project is directed by four partners: the Hamilton County Community Mental Health Board, the Council on Aging of Southwestern Ohio, the Gateway Behavioral Health Network, and core behavioral health centers, which serve as the fiduciary agent.

Interagency planning is under way to improve coordination and collaboration between behavioral health and aging services providers. Currently, principals are trying to secure funds to link the agencies in a more formal arrangement, hoping eventually to use the project as a focal point or clearinghouse for all related referrals.

Resources and Funding
All organizations participating in the Coalition contribute staff time and effort. Initial funding for the ElderReach project came from the Health Foundation of Greater Cincinnati to support curriculum development and evaluation of cross-training on mental health, aging, and substance abuse topics.

The program can provide additional information on its resources and funding.

Getting Started in Cincinnati
Impetus for the formation of the Coalition and the subsequent development of the ElderReach project was the inability of case managers (Mental Health Board) and care managers (Council on Aging) to communicate about clients they had in common.
The care managers in the aging network were finding clients with mental illness and substance abuse issues but did not know how to go about seeking solutions. Similarly, the mental health staff members were not confident in their ability to serve older adults. Representatives of these two organizations began collaborating. Their timely participation in a State-sponsored training seminar on coalition building helped in forming their own coalition. They invited all of the participants in that seminar to join them as they developed a mission statement and goals and began to work in committees: education, advocacy, and systems network development.

The systems network committee began by surveying the aging services case managers on their knowledge of mental health needs and services for the elderly and clearly identified the need for information and training in this area. Further, the Coalition identified the need for increased integration of mental health and aging services. All of these needs could be addressed by bringing the staffs of the two networks together to begin a dialogue and take part in cross-training. The principals then sought funding to support such an endeavor. When presenting the concept to a local foundation, they were encouraged to broaden their collaboration to include the substance abuse network. The partnership was then extended to a fourth organization that fulfills the fiduciary role for the ElderReach grant project. Further, the geographic scope of the project was extended to the bordering States of Kentucky and Indiana.

Training sessions are now underway and have received a high level of interest and enthusiastic feedback from participating staff members who relish the opportunity to learn new information and to forge relationships with the professionals in the other two fields.

Expanded efforts involve training the police and fire department representatives who investigate potential problems identified by the “Are You OK? Program,” a telephone check-in program for elders living alone.

Getting Started in Other Communities
The formation of a mental health and aging coalition can occur in any community that has an interest in collaboration. The ElderReach project, in particular, could be replicated with sufficient interest and commitment. At a minimum, it would require a small amount of start-up funding or in-kind support to cover costs of such necessities as supplies, mailings, meeting places, and gratuities for trainers.

Materials available to other groups interested in developing a coalition include a brochure, descriptive articles, a quarterly newsletter, and a curriculum design for the cross training.

Keys to Success
Cultural competency is required in serving the predominantly Caucasian, African American, and Appalachian clients. In addition, service providers recognize the increasing numbers of immigrants of African, Asian, Russian, and Hispanic origin. They are challenged with addressing the specific cultural needs of these individuals, as well as new language barriers. Staff capacity in other languages is not readily available, but translation is provided for several languages through the assistance of the Jewish Community Center and Travelers’ Aid.
Appendix 1

Nominations of Additional Promising Practices

In developing “Promoting Older Adult Health,” The Substance Abuse and Mental Health Services Administration, the National Council on the Aging, and their advisers searched for promising practices that best reflected success in building the capacity of the aging services network to meet the substance abuse and mental health needs of older people. Many strong nominations were received. Not all could be selected to be profiled in this guide as promising practices. This section presents synopses of programs that were nominated for inclusion in the guide but not selected for profile development. These programs offer additional resources for those interested in developing community and State programs.

These program synopses have been organized in the same four categories used to organize the four sections of the guide:

- Education and Prevention
- Outreach
- Screening, Referral, Intervention, and Treatment
- Service Improvement Through Coalitions and Teams

Education and Prevention

Depression Education and Screening Materials

The Blues: Not a Normal Part of Aging
National Mental Health Association
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Alexandria, VA 22314-2971
Phone: 703/838-7533
Fax: 703/684-5968
email: shalper@nmha.org

The Blues: Not a Normal Part of Aging is a national community education and screening program on clinical depression. It was developed through a partnership between the National Mental Health Association’s Campaign on Clinical Depression and the American Society on Aging (ASA). The program aims to raise awareness about clinical depression and treatment options among older adults and their family members and to facilitate free depression education and screening sessions for older adults. The program tool kit contains detailed instructions as well as a 20-minute video and information on organizing a confidential depression screening. It includes a sample geriatric depression screening form and other
materials for duplication and distribution. The program is a resource for ASA members, mental health associations, and other local health organizations to use in their own communities.

**Medication Management Education**

**Maui Center for Health Care Education**
Contact Person: Cindy Krenk 53 Pulinene Ave., #120 Kahului, HI 96732 Phone: 808/877-2109 Fax: 808/877-2430 email: krenko@maui.net

Since 1996 the Maui Center for Health Care Education has provided health care education programs to seniors, primarily through medication review programs using one-on-one consultations between pharmacists and patients. The review covers prescription medications, over-the-counter medications, and herbal products; health status; and lifestyle and habits. It offers education and information, individualized counseling, and follow-up and referral. The program has reduced mismanagement of prescription and over-the-counter medications by older adults as well as unnecessary hospitalizations and nursing home admissions. Community agencies, service programs, senior housing developments, and local health care professionals participate.

**Older Adults Reaching Out**

**Positive Aging Theater**
Contact Person: Vacant 200 Fordham Ave. Madison, WI 53704 Phone: 608/246-7606, ext 157

The Positive Aging Theater is an energetic group of older adults who voluntarily create an annual entertainment revue performed throughout Dane County, WI. The show changes each year, reflecting the unique talents of that year’s players and directors, but the themes continue from year to year: live life to the fullest; dispel stereotypical myths about aging; support and enhance community and individual spirit and well-being; prevent alcohol and drug abuse; and promote good practices of medication management. Performances take place at senior centers, adult day care centers, coalitions for the elderly, AARP groups, and low-income housing units. Creative forms of presentation, low-budget programming with extensive volunteer involvement, and universally positive audience response are promising aspects of the program. Audience members report the performances give them a feeling of empowerment.

**Prevention Services in Senior Centers**

**Indianapolis Senior Citizens’ Center, Inc.**
Contact Person: Rochelle Cohen 708 E. Michigan St. Indianapolis, IN 46202 Phone: 317/263-6272 Fax: 317/655-0035 email: rcohen@yourcenter.org

The Indianapolis Senior Center, one of the oldest in the country, was opened in 1961. It provides prevention, social, and health services and activities designed by and for older individuals to help prevent premature dependence. Ten years ago it developed a program to provide mental health and addiction treatment and prevention. A full-time master’s-level social worker provides treatment and prevention services at the center. She also trains seniors to be peer counselors so they can reach those who cannot get to the center. Both individual
and group therapy services are offered. This treatment can focus on bereavement, addiction problems, and depression, and can also help with family and marital problems.

**Substance Abuse Prevention and Treatment**

**Project A.L.E.R.T. Adult Well-Being Services**
Contact Person: Central Access Person
1423 Field Ave.
Detroit, MI 48214
Phone: 313/833-3765
Fax: 313/833-3783

Adult Well-Being Services is a private, not-for-profit organization that offers a variety of services and programs to reduce or eliminate problems that interfere with optimal functioning of older adults. The substance abuse program provides services ranging from prevention to treatment. Other programs offer education, treatment, information and referral, nutrition and health education, and case management in a supportive manner. They are specifically paced to meet the needs of older adults and focus on specific psychological, social, and health problems of the elderly. Services are provided in an age-appropriate manner in settings that are not threatening to older adults or difficult for them to reach. Adult Well-Being Services is dedicated to promoting optimal independence and social well-being of adults who are at risk because of age, income, mental or physical health, developmental disability, education, coping ability, or environment.

**Substance Abuse Services Through Multiservice Agency**

**Alcohol and Drug Action Program**
Jewish Family Service of Los Angeles
Contact Person: Jasmina Moore
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Los Angeles, CA 90035
Phone: 310/247-1180
Fax: 310/858-8582
email: adap-jfs@msn.com

The Alcohol and Drug Action Program of Jewish Family Services is a comprehensive program designed to address substance abuse issues, especially within the Jewish community. Services include prevention and general substance abuse education, counseling, information, and referral; social/spiritual events; L’Chaim 12-step meetings (open to anyone in any 12-step program); training; and technical assistance. The Alcohol and Drug Action Program provides training to other programs that work with older adults. It is designed to educate staff about substance abuse in general and issues specific to older adults, including medication and alcohol-related problems. Social workers are available for consultation on specific cases. Jewish Family Services operates numerous other programs, including meals and adult day services, and provides training to other senior organizations.
Outreach

Mental Health Services for Nursing Home Residents

Indiana PASRR Program
Bureau of Aging In-Home Services
Contact Person: Pat Cassanova, R.N.
402 West Washington St., W353
Indianapolis, IN 46204-2739
Phone: 317/232-1731
Fax: 317/232-7867

Indiana has taken the federally mandated PASRR (Preadmission Screening and Resident Review) program one step further. PASRR is a Medicaid program that is intended to ensure that people who have a serious mental illness are not “warehoused” in Medicaid nursing facilities. The PASRR program assesses the service needs of nursing facility applicants and residents and considers appropriate alternatives to nursing home care. Indiana PASRR not only identifies mentally ill nursing home applicants and residents and determines appropriate placement, it also identifies their needs for services, recommends appropriate service providers, and follows up to ensure that appropriate services are provided. This information becomes a part of the resident’s nursing facility file and the facility is held responsible for providing or arranging the necessary services. The State has developed three separate systems to ensure that services are provided. The Mental Health Agency, the Office on Aging, the Health Department, the Medicaid office, the Medicaid intermediary, a Community Mental Health Center, and the area agency on aging are involved.

Mental Health Services in Seniors’ Homes

Geriatric Outreach and Counseling
Contact Person: Ruth Adelman
Trinitas Hospital (previously Elizabeth Geriatric Medical Center)
655 E. Jersey St.
Elizabeth, NJ 07206
Phone: 908/994-7313
Fax: 908/994-7342

This program brings mental health services to seniors who are unable to go to the hospital’s geriatric outpatient clinic. Funded by a grant from the Union County, NJ, Department of Human Services, the program arranges up to eight home visits for patients, with the ultimate goal of linking them to appropriate community services. Staff include an advanced practice nurse and a clinical specialist in geropsychiatry. They can conduct assessments, diagnose problems, provide therapy, and prescribe and monitor medications. The program maintains linkages with the visiting nurse services, hospital inpatient and outpatient programs, Alcoholics Anonymous, and adult day care. It also has developed relationships with social workers and managers in three senior citizen apartment complexes and one local church.

Substance Abuse Services Outreach

Rushford Center Senior Outreach Program
Contact Person: Edwina Ranganathan
1250 Silver St.
Middletown, CT 06457
Phone: 860/346-0300
Fax: 860/346-6417

Rushford Center’s outreach program targets seniors with substance abuse problems. Staff meet with seniors in their homes and in community settings and have links to
the major psychiatric outpatient programs at hospitals in the region. The program has a strong prevention component, aimed at raising health care workers’ awareness of the unique problems of this population. Presentations are made to social workers, housing managers of senior residences, home health organizations, and visiting nurse associations. Through extensive networking, the center builds awareness, maintains links, and enables mutual referrals, providing convenient service locations for residents and resources that might not otherwise be available.

Screening, Referral, Intervention, and Treatment

Addictions Treatment in Holistic Life Enrichment Program

*Lifestyle Enrichment for Senior Adults*
Contact Person: Betty MacGregor
420 Cooper St.
Ottawa, Ontario L2P 2N6 Canada
Phone: 613/233-5430
Fax: 613/233-2062
email: bmacgregor@centretown.chc.org

The Lifestyle Enrichment for Senior Adults program is an addictions treatment program specifically designed to help seniors with problems related to use of alcohol or other psychoactive medication or gambling. The program is holistic and client-centered. Alcohol and medication use are viewed within the context of the person’s life. Interventions are guided by clients’ priorities that may or may not be related to their alcohol or other psychoactive drug use. The program has used a harm reduction approach since its inception in 1979. Abstinence, while often recommended, is not a criterion for admission to the program. Client success is defined in terms of reduced intake and improved quality of life. Often, the client will focus on other areas of concern such as nutrition or social isolation before gaining confidence to reduce or stop using alcohol or psychoactive medications. Not dealing directly with alcohol or drug use minimizes clients’ resistance to change. Evaluation of the program indicates that this approach is very successful with seniors. Counseling and support are provided in individual and group settings. In-home visits are available, as is a Help line for the region and gambling telephone counseling for the province. Services are offered in English and French.

Community-Based Substance Abuse Prevention and Treatment

Community Mental Health Substance Abuse Services
Contact Person: Richard Petty, C.S.W., A.C.S.W.
812 E. Jolly Rd., G14
Lansing, MI 48910
Phone: 517/346-8268
Fax: 517/346-8290

This program of treatment and prevention of substance abuse among older adults, in place since 1983, has developed a system of mutual referral and support with other service providers to older adults. The agency supports a monthly meeting with members of the aging network to exchange information and make appropriate referrals. Staff regularly inform clients of available services such as Meals-on-Wheels, senior transportation, senior companions, professional mental health programs, and community support groups. Staff also offer in-service presentations to mental health counselors at hospitals and counseling centers on substance abuse issues and effective treatment with older adults, and provide similar instruction to students at community colleges and Michigan State
University. Outreach involves screening and treating individuals for substance abuse and mental health problems in their homes, homeless shelters, day-care centers, hospitals, psychiatric units, and in the office.

**Comprehensive Screening**

*Aging and Disability Research Center of Marathon County*

Contact Person: Deb Menacher  
1000 Lakeview Dr.  
Wausau, WI 54403  
Phone: 715/261-6070  
Fax: 715/201-6090  
email: adrc@mail.co.marathon.wi.us

The Aging and Disability Resource Center of Marathon County provides information and assistance and serves as the gateway to the county’s long-term care resources. It provides a comprehensive assessment for individuals with complex or multiple needs, including help for mental health and substance abuse problems. Funded services are available at little or no cost for individuals who need them. Each person works with a Resource Center professional to clarify the individual’s circumstances, identify potential services, and formulate an action plan. If the person needs additional assistance, the Resource Center will provide advocacy in securing services and coordinating resources. The Department of Social Services, private social service agencies, home health care agencies, a hospital, and a medical provider are available as needed.

**In-Home Mental Health Services**

*San Fernando Valley Community Mental Health Center*

Contact Person: Ian Hunter, Ph.D.  
14535 Sherman Circle  
Van Nuys, CA 91405  
Phone: 818/901-4830  
Fax: 818/785-3446  
e-mail: ihunter@sfvmhc.org

The San Fernando Valley Community Mental Health Center’s Homebound Program has been providing mental health services to older adults in the San Fernando Valley since 1979. Services are provided in the client’s home or at the clinic, depending on the client’s needs. In-home services include therapy, supportive counseling, crisis intervention, case management, assessment, and resource identification and linkage. All clients have a serious mental illness. Many have substance abuse issues as well. Interventions include cognitive behavioral therapy, stress management, life review, and ongoing monitoring of the safety of the home environment and of the client’s functioning. The program works closely with home health agencies and confers with medical providers when indicated. Dually diagnosed clients who are mobile enough to attend are referred to 12-step groups at the center’s club house program or in the community. Other treatment referrals include one residential and two partial hospitalization programs, all serving seniors with substance abuse and mental health needs. Medication evaluation and monitoring are provided at the clinic.
Integration of Mental Health and Substance Abuse Services with Primary Care

Bucksport Regional Health Center
Contact Person: John Corrigan
P.O. Box 447
Bucksport, ME 04416
Phone: 207/469-7371
Fax: 207/469-7306

Aging in Place is a program of primary care with integrated mental health and substance abuse services. Care is delivered to older adults at home in this very rural area by a geriatric nurse practitioner. The program’s goal is to delay or prevent institutionalization. Creative approaches have been used to maximize the flexibility of service delivery, to hire qualified clinicians, and to make use of all possible resources. The program has succeeded in filling gaps in service availability and in providing a high volume of services to an otherwise underserved population at comparatively moderate cost.

Mental Health Services at Senior Activity Center

Swanson Center
Contact Person: Larry Miller
450 St. John Rd., Suite 501
Michigan City, IN 46360
Phone: 219/879-4621
Fax: 219/873-2388

Swanson Center is a local community mental health center that has operated an activity center for older adults in La Porte, IN, since 1976. More than 500 members take part in its programs each year. It has developed an advisory board to strengthen the planning process and sharpen the senior center focus, which has included examining ways to expand mental health services and intergenerational services to families. The Swanson Center is also charged with screening persons entering nursing facilities, and it provides mental health and substance abuse services. Services include intensive case management, partial hospitalization, residential care, and outpatient counseling. The activity center is also involved in many activities within the community and offers health education programs, socialization activities, and information and referral services.

Mental Health Services at Seniors Sites and In-Home

New York Service Program for Older People - Senior Outreach Program
Contact Person: Arleen Stern
1888 W. 88th St.
New York, NY 10024
Phone: 212/787-7120, ext. 133
Fax: 212/580-0533

The first program of its kind in New York City, the Senior Outreach Program of the New York Service Program for Older People (SPOP) is a cost-effective, innovative way to provide much-needed mental health services to older adults. SPOP started the program in five senior organizations in June 1997 and now provides services at 11 places frequented by seniors—senior centers, naturally occurring retirement communities, and other sites. The program’s social worker spends one day a week at each of the participating sites, providing individual and group counseling and making home visits to seniors who live near the sites but are homebound. By providing this service on-site, the Senior Outreach Program establishes a “transfer of trust” from the senior center or organization to the mental health professional that facilitates the acceptance of mental health services by this population. This transfer of trust is accomplished by providing comprehensive information to site
staff and by the regular presence of the social worker, creating a positive perception of the program among clients.

**Mental Health Services for Asian Americans**

**Chinatown Health Clinic**  
Contact Person: Henry Chung, MD  
125 Walker St.  
New York, NY 10013  
Phone: 212/226-8866  
Fax: 212/226-2289

The Asian American Primary Care and Mental Health “Bridge Program” of the Chinatown Health Clinic in New York has three goals: to provide mental health services in a primary care setting, to improve the skills of primary care providers in the identification and treatment of mental disorders, and to provide community health education on mental health issues. The program was designed to break down the barriers to delivering mental health care to the Asian American community. This is important because Asian Americans, in comparison with other ethnic groups, underutilize mental health services and have the greatest delay in receiving needed care, resulting in poor treatment outcomes. Reluctance to seek care is attributed to cultural stigma as well as the dearth of bilingual and bicultural treatment. Because this population uses primary care physicians for all care, the focus was to increase access at that point while upgrading the mental health skills of those providers.

**Mental Health Services In-Home and at Senior Centers**

**Geriatric Counseling Program**  
**Intercommunity Action (INTERAC)**  
Contact Person: Cynthia Wishovsky  
6012 Ridge Ave.  
Philadelphia, PA 19128-1697  
Phone: 215/487-1750  
Fax: 215/487-3716  
email: aging@pond.com

The Geriatric Counseling Service at Intercommunity Action in Philadelphia provides a variety of mental health services to older adults in community settings. The goal is to ensure access and minimize stigma. It aims to provide a spectrum of mental health services to the elderly in the community in a supportive and nonthreatening manner and to bridge the gaps between the systems serving elders. Because older adults have not used the traditional community mental health system, this program uses alternate settings to provide mental health assessments; individual and family therapy; referral for medical treatment; supportive group therapy; and screening, educational, and preventive mental health programs. Services are most often offered at consumers’ homes or at senior community centers. Services at the centers include support groups and an annual depression screening, as preventive measures. The program also has a clinician present in the senior center on a regular basis.
Treatment for Alcoholism, Drug Addiction, Related Diseases

Hanley-Hazelden Center at St. Mary’s
Contact Person: Carol Colleran, C.A.P., I.D.A.D.C.
5200 East Ave.
West Palm Beach, FL 33407-2374
Phone: 561/841-1131
Fax: 561/841-1151
email: ccolleran@hazelden.org

Hanley-Hazelden Center at St. Mary’s, part of the internationally recognized Hazelden Foundation that pioneered the model of care for alcoholism, drug addiction, and related diseases, is the leader that established the treatment model specifically designed for older adults. This model is a multidisciplinary residential treatment program that provides quality rehabilitation, education, and professional services in a setting that meets the needs of an older population. The specialized services include extended detoxification and medical stabilization, slower transition between levels of care, and increased individual staff contact. Hanley-Hazelden also provides extended care, family programs, and education and prevention programs.

Veterans Administration Substance Abuse Services

GET SMART/UPBEAT (Geriatric Evaluation Team: Substance Misuse/Abuse Recognition and Treatment (GET SMART) and Unified Psychogeriatric Biopsychosocial Evaluation and Treatment (UPBEAT))
Contact Person: Catherine Royer, L.C.S.W.
West Los Angeles Veterans Administration Healthcare Center
11301 Wilshire Blvd.
Los Angeles, CA 90073

This program serves veterans age 60 and older with problems of substance abuse, depression, or anxiety. Because many are screened and referred from non-psychiatric sources, ongoing education of medical staff and community-based agencies is emphasized. The program seeks to connect the veterans with treatments appropriate to the range of their psychosocial and medical issues, resulting in increased quality of life and appropriate use of services. Treatment modalities include pro-active and preventive care coordination; use of support groups and other group treatment; a “Health Effects of Substance Use” motivational group; and a cognitive-behavioral group. Treatment includes working closely with Veterans Administration and community resources to provide basic services such as coordinated medical care, housing, transportation, Alcoholics Anonymous, and sobriety support programs.

Service Improvement Through Coalitions and Teams

Statewide Training for Local Geriatric Services
Contact Person: Maureen Haugh-Stover
Illinois Department of Human Services Office of Mental Health
400 Stratton Bldg.
Springfield, IL 62765
Phone: 217/785-6023
Fax: 217/785-3066
email: dhsmhy@dhs.state.il.us

In coordination with the State Department of Human Services Office of Mental Health, the State Department on Aging, and a 20-member statewide Advisory Committee on Geriatric Services, Illinois has implemented a training practice to enhance the coordination, linkage, communication, and delivery of mental health services to older adults. A Mental Health and Aging Team...
Building and Skill Enhancement Training initiative targets selected areas of the State and brings the mental health and aging services providers together for a 6-week training program that focuses on system integration and skill enhancement in the provision of mental health and aging services to older adults with mental health needs. These training initiatives have been successful in enhancing skill competencies in the area of geriatric mental health, enhancing networking and coalition building, and increasing mental health services to older adults.

**Linking of Aging Agencies and Mental Health/Substance Abuse Networks**

**Wisconsin Office of Mental Health**
Contact Person: Cathy Swanson Hayes
Office of Mental Health
Department of Health and Social Services
P.O. Box 7851
Madison, WI 53707-7851
Phone: 608/267-7288
Fax: 608/267-7793
e-mail: swanscl@dhfs.state.wi.us

The Wisconsin Office of Mental Health has a strong aging initiative with a statewide coalition that uses Mental Health and Substance Abuse Block Grant dollars to support public awareness of mental health and substance abuse issues of older persons, skill development training conferences, and local coalition building activities. Area agencies on aging played a major role in organizing and hosting these conferences, and an agency director is the chair of the State coalition and has addressed the State Mental Health and Substance Abuse Councils. Area agencies have hosted gatherings with State and Federal legislators, and supported local coalition building activities. Other collaborative efforts by mental health and aging advocates resulted in State legislation creating a new in-home mental health and substance abuse service that makes assistance and treatment accessible, acceptable, and affordable for older persons. This effort to tailor in-home services to the mental health and substance abuse needs of older persons began in 1986 with a local collaborative effort of the Aging and Mental Health/Substance Abuse networks in Dane County, supported by a Federal grant. When the grant ended, advocacy efforts led to ongoing support with county funds. Elements of this model project shape the new in-home service available to all age groups. Eleven counties have local initiatives under way, actively linking the aging and mental health/substance abuse networks.

**Professional Education and Cooperation**

**Health Promotion Initiative**
Contact Persons: Gerry Mackenzie, Marilyn Engstrom
New Jersey Department of Health and Senior Services
P.O. Box 807
Trenton, NJ 08625
Phone: 609/588-3466
Fax: 609/588-3601

The Health Promotion Initiative is a cooperative project of the New Jersey Department of Health and Senior Services, the Geriatric Education Center at the University of Medicine and Dentistry of New Jersey (School of Osteopathic Medicine), and county health and aging coalitions. The program has two goals: to provide professional education at the local level to health and aging services providers, and to foster greater working relationships among health and aging professionals. Under the initiative, 2 days of professional education are provided to 30 professionals. The participants, chosen by a local planning group,
represent both health and aging services. The local planning group selects one of three topics for training: mental health and aging, falls assessment and prevention, or drug use/misuse. Following the training, the coalition implements a program initiative or structural/procedural change in the service area identified. Health departments, offices on aging, crisis centers, mental health providers, community-based service providers, police departments, visiting nurse associations, and senior centers are involved.

**State Mental Health Service Models**

**Michigan Department of Community Health**

Contact Person: Irene Kazieczko  
320 South Walnut  
Lansing, MI 48913  
Phone: 517/373-2845  
Fax: 517/241-2969  
email: kazieczko@state.mi.us

The focus of the Michigan Department of Community Health has been to develop service models that serve older persons with lifelong chronic mental illness/substance abuse and those with late-onset conditions. The department launched a number of initiatives to increase the capacity of the State and local service system. One was to include this group as an underserved population in the State’s comprehensive plan for mental health services; another was to include individuals with dementia plus depression, delusions, or behavioral disturbance in the State’s definition of serious mental illness. Block grant funds and Alzheimer’s demonstration funding were used to leverage resources for development of new collaborative service models for older adults. Six suicide prevention programs were funded, all focused on community education to raise awareness of depression symptoms and reduce barriers to treatment. Michigan has another six statewide best practice initiatives (including a statewide library of resources) and five local best practice models.

**Statewide Task Force on Substance Abuse Awareness**

**Massachusetts Geriatric Substance Abuse Task Force**

Contact Person: Ruth Grabel  
Office of Elder Health  
Massachusetts Department of Public Health  
250 Washington St., 4th floor  
Boston, MA 02108  
Phone: 617/624-5411  
Fax: 617/624-5075  
email: ruth.grabel@state.ma.us

The Massachusetts Geriatric Substance Abuse Task Force was established in 1987 by a small group of health professionals concerned about the lack of attention to substance abuse and the elderly. The group operates with support from the Department of Public Health’s Bureau of Substance Abuse Services, Bureau of Family and Community Health, and Office of Elder Health. The Task Force conducts monthly meetings with speakers in the field of substance abuse and addiction among older people. It offers workshops and presentations at conferences and meetings, including the annual statewide conference of the Councils on Aging. It also disseminates information and materials, participates in statewide assessment and planning activities, and convenes a yearly statewide Aging with Dignity conference on elders and substance abuse. The conference brings together representatives of the councils on aging and elder service network with health professionals from health care institutions and consumer groups.
Appendix 2
National Partner Organizations

Administration on Aging
www.aoa.gov
Melanie Starns
200 Independence Avenue, SW
HHH Building, Room 309-F
Washington, DC 20201
Phone: 202/401-4547

AARP
www.aarp.org
Carol Cober
601 E Street, NW
Washington, DC 20049
Phone: 202/434-2263

American Managed Behavioral Health Care Association
www.ambha.org
Pamela Greenberg, Ph.D.
700 13th Street, NW
Suite 950
Washington, DC 20005
Phone: 202/434-4565

American Society on Aging
www.asaging.org
Patrick Cullinane
833 Market Street
Suite 511
San Francisco, CA 94103-1824
Phone: 415/974-9642

Bazelon Center for Mental Health Law
www.bazelon.org
Robert Bernstein, Ph.D.
1101 15th Street, NW, Suite 1212
Washington, DC 20005
Phone: 202/467-5730

Gerontological Society of America
www.geron.org
Carol Schutz
1030 15th Street, NW
Suite 250
Washington, DC 20005-1503
Phone: 202/872-1275

Constance L. Coogle, Ph.D. and
Nancy Osgood, Ph.D.
Virginia Commonwealth University
P.O. Box 980229
520 North 12th Street
Richmond, VA 23298
Phone: 804/828-1525

Hanley-Hazelden Center at St. Mary’s
www.hazelden.org
Carol Colleran
5200 East Avenue
Palm Beach, FL 33407
Phone: 561/841-1131
National Council for Community Behavioral Healthcare
dwww.nccbh.org
Pope Simmons
12300 Twinbrook Parkway
Suite 320
Rockville, MD 20852
Phone: 301/984-6200

National Hispanic Council on Aging
www.incacorp.com/nhcoa
Marta Sotomayor
2713 Ontario Road, NW, Suite 200
Washington, DC 20009
Phone: 202/745-2521

National Indian Council on Aging
dwww.nicoa.org
Dave Baldridge
1501 Montgomery Boulevard, NE
Suite 210
Albuquerque, NM 87111
Phone: 505/292-2001

Bill Benson
NICA
7106 Maple Avenue #2
Silver Spring, MD 20912
Phone: 202/225-2001

National Institute of Senior Centers (NCOA)
www.ncoa.org
Ronald W. Schoeffler
535 15th Street
Augusta, GA 30901
Phone: 706/826-4480

National Mental Health Association
www.nmha.org
Shela Halper
1021 Prince Street
Alexandria, VA 22314-2971
Phone: 703/838-7533

Substance Abuse and Mental Health Services Administration
www.samhsa.gov
Jennifer Fiedelholtz
5600 Fisher Lane
Parklawn Building
Room 12C-05
Rockville, MD 20857
Phone: 301/443-5803

Eileen Elias
5600 Fishers Lane
Parklawn Building
Room 13C-20
Rockville, MD 20857
Phone: 301/443-8742

Jennifer Solomon
Center for Substance Abuse Prevention
5600 Fishers Lane
920 Rockwall Building II
Rockville, MD 20857
Phone: 301/443-6924

University of Michigan Alcohol Research Center
Frederic C. Blow
400 East Eisenhower Parkway, Suite A
Ann Arbor, MI 48108-3318
Phone: 734/930-5139
Appendix 3

Select Federal Agencies and National Organizations Providing Resources to Address Medication, Alcohol, and Mental Health Problems Among Older Adults

Substance Abuse and Mental Health Services Administration
www.samhsa.gov
The Substance Abuse and Mental Health Services Administration (SAMHSA) works to strengthen the Nation’s health care capacity to provide prevention, diagnosis, and treatment services for substance abuse and mental illnesses. SAMHSA works in partnership with States, communities, and private organizations to address the needs of people with substance abuse problems and mental illnesses as well as the community risk factors that contribute to these illnesses. Organizationally, SAMHSA serves as the umbrella for the Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT).

SAMHSA's web site features general information on the agency’s current initiatives and program areas, including overviews of programs and activities in each of its three centers, as well as information to assist in locating substance abuse or mental health treatment programs. The web site also provides access to the SAMHSA information clearinghouses—the National Mental Health Services Knowledge Exchange Network (KEN), the National Clearinghouse for Alcohol and Drug Information/PREVLINE, and the Treatment Improvement Exchange (TIE) Network. These clearinghouses are a key source of information for a range of audiences, and most of SAMHSA's publications can be ordered free of charge from these clearinghouses. The web-based statistical resources of SAMHSA’s Office of Applied Studies (OAS) can also be accessed through the SAMHSA web page. The OAS resources include highlights from the latest OAS reports and data on specific drugs of abuse, as well as public use data files. OAS publications can be ordered online from this web site.

Center for Mental Health Services
www.samhsa.gov/centers/cmhs/cmhs.html
SAMHSA’s Center for Mental Health Services (CMHS) works to create an effective community-based mental health service infrastructure in the United States. CMHS’s foremost goals are to improve the availability and accessibility of high-quality care for people with or at risk for mental illnesses and their families.
In addition to information about CMHS’s major programs and activities, the CMHS web site provides information and resources on a range of mental health topics, including information about special populations such as older adults. CMHS also provides access to the National Mental Health Services Knowledge Exchange Network and links to other public and private sources of information on mental health issues.

Center for Substance Abuse Prevention
www.samhsa.gov/centers/csap/csap.html
SAMHSA’s Center for Substance Abuse Prevention (CSAP) is the Nation’s focal point for the identification and promotion of effective strategies to prevent substance abuse—whether illicit drug use, misuse of legal medications, use of tobacco, or excessive or illegal use of alcohol. To that end, CSAP works to give all Americans the tools and knowledge they need to help reject substance abuse by strengthening families and communities and by developing knowledge of the types of prevention that work best for different populations at risk for substance abuse.

CSAP’s web site provides general information about the programs and activities sponsored by CSAP as well as links to CSAP’s Model Prevention Programs web site and the new CSAP Decision Support System (DSS). The DSS guides States and community-based organizations in identifying effective substance abuse prevention programs and adapting them to the specific needs of the State or community. CSAP’s web site also links to the SAMHSA National Clearinghouse for Alcohol and Drug Information, which provides a wide range of publications, videotapes, and other prevention resources to the public, most of which are available free of charge.

Center for Substance Abuse Treatment
www.samhsa.gov/centers/csat/csat.html
SAMHSA’s Center for Substance Abuse Treatment (CSAT) is leading the Nation’s effort to enhance the quality of substance abuse treatment services and ensure their availability to people who need them. It works to identify, develop, and support policies and programs that enhance and expand science-based, effective treatment services for individuals who abuse alcohol and other drugs and that address individuals’ addiction-related problems.

CSAT’s web site includes general information about CSAT’s programs and activities, as well as statistics, research findings, training resources, publications, and other web-based information on a variety of topics related to substance abuse treatment. In addition to linking with SAMHSA’s National Clearinghouse for Alcohol and Drug Information, the CSAT web site links with the Treatment Improvement Exchange (TIE), a CSAT-sponsored resource to exchange information among Federal, State, and local alcohol and substance abuse agencies and others on substance abuse related topics.

The National Council on the Aging, Inc.
www.ncoa.org
NCOA is the Nation’s first association of professionals dedicated to promoting the dignity, self-determination, well-being, and contributions of older persons. NCOA’s members include senior centers, area agencies on aging, adult day services, faith congregations, senior housing, health centers, employment services, and consumer organizations. NCOA helps community organizations to enhance lives of older adults by turning creative ideas into programs and services that help older people in hundreds
of communities. NCOA is a national voice and powerful advocate for public policies, societal attitudes, and business practices that promote vital aging.

The NCOA web site is divided into two major sections, the visitors’ and members’ sites. The visitors’ section provides general information about NCOA and its affiliates, as well as information about NCOA’s programs, advocacy and public policy information relating to older adults, research findings, and linkages to a variety of national organizations and programs addressing aging-related issues. Member Central, the members-only section, links members to the latest NCOA and aging networks news, alerts to new services, and discussion topics on the NCOA online forums.

**Administration on Aging**

[www.aoa.gov](http://www.aoa.gov)

The Administration on Aging (AoA) is the Federal focal point for services to older Americans. Under the Older Americans Act, the AoA and its nationwide network of State and Area Agencies on Aging, Tribal Organizations, and service providers plan, coordinate, and develop community-level systems of services that help vulnerable older persons to remain in their homes and communities. A range of Older Americans Act-supported services are offered at the State and local levels, including nutrition, transportation, information and assistance, the long-term care ombudsman program, and legal services.

AoA’s web site contains information for older persons and their families, practitioners, the aging network, and researchers and students, including a resource directory of organizations relevant to older persons and an online guide for caregivers.

**National Institute on Aging, NIH**

[www.nih.gov/nia](http://www.nih.gov/nia)

The National Institute on Aging (NIA), part of the National Institutes of Health (NIH), conducts interdisciplinary research, provides medical and scientific training, and disseminates health-related information to professionals in the field of aging processes and age-related diseases, including Alzheimer’s disease.

The NIA web site contains information on recent news and events, extra- and intramural research programs, research grants, and resources relating to Alzheimer’s disease. The site also includes links to health-related publications and resources, training opportunities, and the affiliated National Advisory Council on Aging.

**AARP**

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

AARP is the Nation’s leading organization for people age 50 and older. It serves their needs and interests through information and education, advocacy, and community services, which are provided by a network of local chapters and experienced volunteers throughout the country. The organization also offers members a wide range of special benefits and services, including *Modern Maturity* magazine and the monthly *Bulletin*.

AARP’s web site features a wide range of resources for members as well as the general public. In particular, AARP provides information and other resources on a variety of issues relating to health and wellness for older adults, including stress management, grief and bereavement, proper nutrition, alcohol abuse, and prescription drug use. Publications and other materials are available for many of the topics addressed online, and resources are provided for a range of audiences, from health professionals to members of the public.
### ALABAMA

**State Contact:** Roxanna Bender  
harperRTB@simplecom.net  
and Sheila Blackshear

**State Coalition Contact:** Rebecca Ray Perl  
(256) 582-3203

**Local Coalition Contact:** None at this time

### ARIZONA

**State Contact:** Karla Averill  
kaveril@hs.state.az.us

**State Coalition Contact:** Cheryl Becker  
mhacheryl@uswest.net  
(480) 994-4407  
(480) 994-4744

**Local Coalition Contact:** None at this time

### ARKANSAS

**State Contact:** Kaye Kundahl  
kkundahl@aol.com

**State Coalition Contact:** Betty French  
byfrench@aol.com  
(501) 682-8150  
(501) 682-8155

**Local Coalition Contact:** None at this time

### CALIFORNIA

**State Contact:** Jane Laciste  
jlaciste@dmhhq.state.ca.us

**State Coalition Contact:** None at this time

**Local Coalition Contact:** Mental Health & Aging Coalition  
MhandAgingCoa@excite.com

**Phone**  
(916) 654-3529  
(916) 653-6486

**FAX**
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<td>State Contact</td>
<td>Fred Acosta</td>
<td>(303) 866-7403</td>
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<td><a href="mailto:fred.acosta@state.co.us">fred.acosta@state.co.us</a></td>
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<td>Jennifer Glick</td>
<td>(860) 418-6643</td>
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<td>Renata J. Henry</td>
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<td>James Noble</td>
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<td><a href="mailto:jim_noble@DCF.state.fl.us">jim_noble@DCF.state.fl.us</a></td>
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<td>State Coalition</td>
<td>Mary Brennan</td>
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<td><a href="mailto:iwest@fmhi.usf.edu">iwest@fmhi.usf.edu</a></td>
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<td>Ken Brandon</td>
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<td><strong>INDIANA</strong></td>
<td>Andrew P. Klatte</td>
<td>(317) 232-7935</td>
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<td>Nancy Trout</td>
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<td>Annette Graham, LMSW</td>
<td>(316) 383-7298</td>
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<td>MISSOURI</td>
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<td>MONTANA</td>
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<td>Margaret Morrill, Chair</td>
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<td>PENNSYLVANIA</td>
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<td>– Northwest Region:</td>
<td>(215) 751-1800</td>
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<td>Tom Volkert</td>
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<td>Dennis Gourley</td>
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<td>– Southeast Region:</td>
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<td>Kim Stucke</td>
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<td>Mary Anne Kelly</td>
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<td>RHODE ISLAND</td>
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<td>TEXAS</td>
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<td><a href="mailto:galen.brewer@mhmr.state.tx.us">galen.brewer@mhmr.state.tx.us</a></td>
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<td>State Coalition Contact: Galen Brewer</td>
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<td>WASHINGTON</td>
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<td>Cathy Swanson-Hayes</td>
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<td>State Coalition Contact:</td>
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<td>Local Coalition Contact:</td>
<td>James F. Truchan</td>
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<td>Local Coalition Contact:</td>
<td>Jane Alexopoulos</td>
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<td>(920) 469-8967</td>
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<td>(414) 289-6376</td>
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Appendix 5

Short Michigan Alcoholism Screening Test—Geriatric Version (S-MAST-G)

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1. When talking with others, do you ever underestimate how much you actually drink? ____  ____

2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn’t feel hungry? ____  ____

3. Does having a few drinks help decrease your shakiness or tremors? ____  ____

4. Does alcohol sometimes make it hard for you to remember parts of the day or night? ____  ____

5. Do you usually take a drink to relax or calm your nerves? ____  ____

6. Do you drink to take your mind off your problems? ____  ____

7. Have you ever increased your drinking after experiencing a loss in your life? ____  ____

8. Has a doctor or nurse ever said they were worried or concerned about your drinking? ____  ____

9. Have you ever made rules to manage your drinking? ____  ____

10. When you feel lonely, does having a drink help? ____  ____

TOTAL S-MAST-G SCORE (0–10) _____________________

Scoring: Two or more “yes” responses is indicative of an alcohol problem.

For information, contact Frederic C. Blow, Ph.D., University of Michigan Alcohol Research Center, 400 E. Eisenhower Parkway, Suite A., Ann Arbor, MI 48104, 734-998-7952.
Appendix 6
Fax Back Form

To: National Council on the Aging—Mental Health Programs / Fax 202-479-0735

From: _____________________________________________________________

Organization: _______________________________________________________

Address: ____________________________________________________________

Telephone: ______________________ Fax: _______________________________

Type of organization: _________________________________________________

Date: __________________________________________________________________

Reactions to Promoting Older Adult Health: Aging Network Partnerships to Address Medication, Alcohol, and Mental Health Problems

Is this guide helpful to you?_____________________________________________

______________________________________________________________________

Do you plan to use material in this publication? ________________________________

______________________________________________________________________

How do you plan to use the information in this guide? _________________________

______________________________________________________________________

If you have contacted programs described here, has this been helpful? ________________

______________________________________________________________________

Does your organization have contact with substance abuse service providers? ___________

______________________________________________________________________

Does your organization have contact with mental health service providers? ___________

______________________________________________________________________

What other types of information would be helpful to you and your organization? ________

________________________________________________________________________