

# Project Evaluation

## Promotion of Early Detection of Depression and Other Mental Illnesses

A project designed for  
Service Coordinators in Affordable Housing



### **A partnership among**

Georgia Association of Homes and Services for the Aging  
Georgia Institute on Aging  
Healthcare Research, Inc  
The Fuqua Center for Late-Life Depression,  
Emory University Division of Geriatric Psychiatry

June, 2008



**PROJECT EVALUATION:**

**Promotion of Early Detection  
of Depression and Other Mental Illnesses:  
Partnership Between The Fuqua Center For Late-Life  
Depression / Emory University Division of Geriatric Psychiatry  
and Georgia Association of Homes and Services For the Aging  
/ Georgia Institute on Aging**

**June 2008**

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Georgia Medical Care Foundation

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- John Abel, Kirsi Ayre and Kisha Frank (Emory University Public Health students) for helping to develop the evaluation plan for this project
- Jennifer Meeker (University of Georgia Social Work student) for conducting the telephone interviews with service coordinators and facility administrators

### **Fuqua Center Staff**

Eve H. Byrd, MSN, MPH, APRN-BC; Executive Director

Catherine Ivy, LCSW; Associate Director

Nancie Vito; Program Coordinator

Sherry Dey, MSN, APRN-BC; Clinical Nurse Specialist

Carol Baylor, RN; Health Educator

### **GAHSA/Georgia Institute on Aging Staff**

Walter O. Coffey, MPA, CAE; President/CEO

Jacque Thornton; Senior Vice-President

Barry Lastinger; Events Coordinator

Susan Watkins; Membership/Office Manager

## **Purpose of Project**

Brief background: Approximately 25% of community dwelling older adults experience symptoms of depression which warrant treatment. Older adults with depression experience greater physical disability, poorer quality of life including loss of life to suicide and incur greater medical expenses and caregiver expenses. Undiagnosed depression results in 50% higher health care costs. Additionally, the cost of care giving for older adults with depression is estimated to be \$9 billion nationally.

Depression is the leading risk factor for suicide. Nationally, older adults make up 13% of the population and 20% of the completed suicides. Unfortunately, the suicide rate among Georgians >75 years of age and older is the highest in the state at 20.8 per 100,000.

Factors considered to be protective with regard to the risk of depression, and ultimately suicide, include good social support, meaningful activities, spiritual connection, and varied roles in the family and community. Unfortunately, many older adults lose these protective factors as they age because of physical conditions or life circumstances that lead to isolation. This can be just as common in congregate living settings where residents live in close proximity to one another but may not be able or choose to interact with their peers.

The 1999 Surgeon General's Report noted that there would never be enough mental health professionals to meet the mental health needs of Americans. Therefore, organizations like the Fuqua Center must partner with organizations such as GAHSA and

their members dedicated to serving older adults in order improve the identification and older adults' access to persons needing psychiatric care.

### Literature Review

Research has reported that suicide rates increase with age and are highest among Americans aged 65 and older. Beginning in the 1980s, significant increases in suicide rates were noted to occur in individuals between 80 and 84 years of age. Several primary risk factors for suicide among the elderly consist of a higher prevalence of depression, physical illnesses, and social isolation. The most common overlooked risk factors include barriers in accessing mental health treatment and stigma associated with mental illness (DHHS, 1999). The elderly also have a higher male to female ratio and have often visited a health care provider before attempting suicide (Garland et al, 2006).

Effective mental health treatment which provides clinical interventions and ongoing support from medical and mental health care relationships (DHHS, 1999) serves as the greatest single protective factor guarding against suicide but is hampered by the stigma around obtaining treatment among the older adult population.

Although several studies have identified many risk factors associated with suicide and the elderly, community providers are increasing treatment efforts by establishing and evaluating suicide prevention programs. A recent study conducted on the utilization of screening tools to reduce elderly suicide risks, concluded the importance of implementing and training providers with this form of measure. Additional recommendations revealed that when elderly patients with a co-morbid illness are diagnosed with depression,

clinicians should be equipped with tools for identifying signs of suicidal behavior. These skills will assist in providing more effective treatment plans in managing the patient (Labisi, 2006)

Primary Stakeholders: Primary stakeholders of this project include Fuqua Center of Emory University, Georgia Association of Homes and Services for the Aging (GAHSA) / Georgia Institute on Aging (GIA), Georgia Medical Care Foundation (GMCF) and service coordinators. Secondary stakeholders include American Association of Homes and Services for the Aging (AAHSA) and residents of 16 residential facilities.

Project Overview and Activities:

This collaboration between the Fuqua Center for Late-Life Depression of Emory University and the Georgia Association of Homes and Services for the Aging (GAHSA) involved a year-long partnership which involved training in depression training for service coordinators (SCs) in low-income senior living facilities. Staff from the Fuqua Center (which is within Emory's Division of Geriatric Psychiatry) provided educational trainings on depression in older adults to service coordinators (bachelor's or master's prepared) who represented 16 different senior living communities. Generally, two service coordinators from each of the facilities attended the trainings. A total of five (5) face-to-face educational trainings were held once a month: May, June, July, August and September 2007. Topics of the trainings include recognizing depression, using screening tools, identifying treatment options, referring to appropriate resources, and appropriate response to suicidal ideation. After the five trainings were held, six monthly case

conferences (via teleconference) were held by a registered nurse with geriatric psychiatry expertise (Carol Baylor, RN) in order for the service coordinators to have an opportunity to ask questions and apply the skills and knowledge learned from the trainings with residents in the sixteen senior living communities.

Content of the five face-to-face trainings:

*Training 1 (May 9, 2007):* This training provided an overview of mental illness and older adults, including the prevalence, symptoms, causes, sadness versus depression, as well as an overview of other illnesses such as dementia and bipolar disorder. Stigma of mental illness was also addressed. Eve Byrd, MSN, MPH, APRN-BC of the Fuqua Center led this workshop. Handouts for this workshop included PowerPoint slide handouts, an information sheet on depression in older adults which can be copied for residents, and fact sheets on Alzheimer's disease and mild cognitive impairment. Service coordinators completed a pre-training survey at the beginning of this session.

*Training 2 (June 13, 2007):* The objective of the second face-to-face training was to introduce implementation of screening tools and identification of appropriate treatment resources. Screening tools introduced were the Geriatric Depression Scale (GDS), the Patient Health Questionnaire – 9 (PHQ-9), the Cornell Scale for Depression in Dementia (CDSS), the Mini Mental Status Exam (MMSE), and the Mini Cog / Clock Drawing Test. Imminent risk versus non-imminent risk was discussed as well as appropriate types of resources when imminent risk is present. This training began the task of identifying resources for mental health services used by individual service coordinators and sharing

information about those resources between service coordinators. The task of resource identification took on a prominent function in subsequent trainings and telephone conferences since service coordinators now felt a distinct need to make mental health referrals following positive screening for depression.

*Training 3 (July 11, 2007):* The topic for the third training was treatment options for depression in older adults. Sherry Dey, MSN, CNS of the Fuqua Center led this training. Symptoms of late-life depression were reviewed as well as barriers to care. Treatment options discussed include the different types of medications, psychotherapy, group therapy, day treatment / partial hospitalization, electroconvulsive therapy (ECT), as well as treatments currently being tested such as transcranial magnetic stimulation (TMS). Handouts for this session included an information sheet on cognitive-behavioral therapy (developed by the National Alliance for Mental Illness), a brochure on a study on transcranial magnetic stimulation, an information sheet on ECT, a list of psychotropic medications, a medication dosage table, and a sheet developed by Mental Health America entitled “Ten ways for Improving the Mental Health of Older Adults.”

*Training 4 (August 8, 2007):* During the fourth session, Nancie Vito of the Fuqua Center trained service coordinators on the Question, Persuade, Refer (QPR) Gatekeeper Training program for Suicide Prevention. This program has been used nationwide in a variety of settings and has been recognized by the Suicide Prevention Resource Registry (SPRC) and the American Foundation for Suicide Prevention (AFSP) as a best practice.

The training itself lasted approximately 2 hours and consisted of a combination of lecture, video, discussion and role play. General goals were to raise the participants' awareness about suicide, provide facts regarding suicide to dispel myths and misconceptions, and teach them some of the warning signs of suicide. The objectives of this training were to enhance service coordinators' ability to recognize and appropriately respond to suicide risk in their resident population and to be able to select from a referral list that included local hospitals, crisis lines, suicide lines, counselors and therapists. Handouts for this session included a QPR booklet developed by the QPR Institute and three fact sheet regarding suicide in older adults. Participants took a pre quiz at the beginning of this training and the same quiz the same day at the end of the session.

*Training 5 (September 5, 2007):* The focus of training 5 was identification of resources and making appropriate mental health referrals. Participants reviewed resource lists developed in session 2, added additional resources discovered in subsequent months, and discussed appropriate referral methods for mental health services. Patrice Earnest of the Atlanta Regional Commission conducted a presentation on the Enhanced Service Provider (ESP) database which includes mental health resources for older adults. Additionally, Laurie Graffo of Georgia Cares presented on Medicare and mental health coverage. Resource lists were distributed regarding caregiver resources, Georgia mental health and aging resources as well as national resources. Additionally, Medicare resources were distributed via the email listserv after the training.

## **Methods**

The GAHSA and Fuqua Center mental health project has a long-term goal of increasing depression recognition, increasing access to mental health care, and decreasing suicide rates in elderly residents within 16 designated residential facilities through training service coordinators in appropriate recognition and referral for mental health care. This goal is supported by a training intervention for service coordinators designed to improve their knowledge, skills, and attitudes regarding mental health, particularly depression and suicidal behavior. In selecting a design to evaluate the correlation between activities and outcomes and the long-term goal, the Kilpatrick model study design will be implemented.

One of the most widely used models utilized for evaluating training programs is the Four Level Model developed by Donald Kilpatrick. These levels consist of reaction, learning, behavior, and results. The first level, reaction, will measure the service coordinators' receptiveness towards the training and long-term impact. Second level, learning, involved the service coordinators' being asked to complete a pre test (baseline: May 2007), a mid-training test (September 2007), and post-training test (May 2008) to evaluate any changes or increase in their knowledge, skills, and attitudes regarding depression and suicide. Level three, behavior will be assessed through a focus group and phone surveys with the Administrators at the facilities involved. Lastly, level four, results, will be recommended for the program in measuring long term outcomes due to the necessity of having a longer follow up period. In addition, the design will effectively provide feedback from the results of the training session which will clarify the program's goals, processes, and objectives.

## **a. Data Sources**

### **1. The Service Coordinators**

Service coordinators provided data via pre- and post-tests. A sample of the service coordinators provided data during the 3 month focus group. Service coordinators also provided archival data by signing the sign-in sheet at the training.

### **2. The Administrators of the Senior Living Communities**

Administrators provided data via phone surveys in May 2008 at the end of the year-long training. This data consisted of information about any changes in their facilities regarding depression and suicide after the trainings were conducted.

## **b. Data Collection Instruments**

As previously mentioned, data were collected from two primary sources and several secondary sources. Methods included pre/posts tests, an informal focus group, archival data, and phone surveys.

### **1. Written Pre- and Post- Tests**

These written tests were administered to the service coordinators participating in the training immediately before the start of the first training (May 2007), and immediately after the conclusion of the fifth training (September 2007). Additionally, the same test was administered via a web-based tool (SurveyMonkey) at the conclusion of the case conferences in April 2008. In addition to these tests at three time points (May, September, and April), pre and post tests were given immediately before and immediately after the QPR training in August 2007.

## **2. Focus Group**

An informal focus group was conducted with a self-selected sample of the service coordinators who participated in the training. This took place 3 months into the year-long project. These focus group questions allowed for information to be obtained regarding changes in the service coordinators attitudes and behaviors toward depression and suicide prevention as well as any gaps in services and challenges. These will provide information at Kirkpatrick's levels 2 and 3.

## **3. Archival Data**

The following provide archival data:

- a. The sign-in sheets from the trainings provide information on which service coordinators were trained and document that the training took place. Sign-in sheets from all face-to-face trainings are available with the exception of training 2.
- b. The PowerPoint presentations and QPR Program training materials provide information about the actual training program.
- c. This project's Logic Model is archival data used to answer any stakeholder questions regarding the project's outputs.

## **4. Phone Surveys**

Two phone surveys/discussions were conducted to collect data.

- a. One phone survey was conducted between an external interviewer (a graduate student from University of Georgia) with facility administrators during the months of April – May 2008. These conversations were used as an educational opportunity to remind the administrators of the training that the service coordinators recently undertook.

These interviews are helpful in determining any changes in the culture of their facilities regarding depression and suicide prevention.

b. The purpose of the second telephone survey, also conducted in April / May 2008, was to glean qualitative information directly from the service coordinators.

### **PROGRAM OUTPUTS**

<b><u>Number of facilities represented:</u></b>	<b>16</b>
<b><u>Number of face-to-face trainings held:</u></b>	<b>5</b>
<u>Number of Service Coordinators who attended Training 1 (5/9/07):</u>	<u>24</u>
<u>Number of Service Coordinators who attended Training 2 (6/13/07):</u>	<u>n/a</u>
<u>Number of Service Coordinators who attended Training 3 (7/11/07):</u>	<u>22</u>
<u>Number of Service Coordinators who attended Training 4 (8/8/07):</u>	<u>25</u>
<u>Number of Service Coordinators who attended Training 5 (9/5/07):</u>	<u>28</u>
<b><u>Number of Case Conferences (CC) held:</u></b>	<b>6</b>
<u>Number of Service Coordinators present at CC 1 (11/7/07):</u>	<u>~20</u>
<u>Number of Service Coordinators present at CC 2 (12/5/07):</u>	<u>~10</u>
<u>Number of Service Coordinators present at CC 3 (1/2/08):</u>	<u>~8</u>
<u>Number of Service Coordinators present at CC 4 (2/6/08):</u>	<u>~12</u>
<u>Number of Service Coordinators present at CC 5 (3/5/08):</u>	<u>9</u>
<u>Number of Service Coordinators present at CC 6 (4/2/08):</u>	<u>n/a</u>

### **Project Outcomes**

Education level of service coordinators:

Bachelor's degree: 53%  
Master's degree: 41%

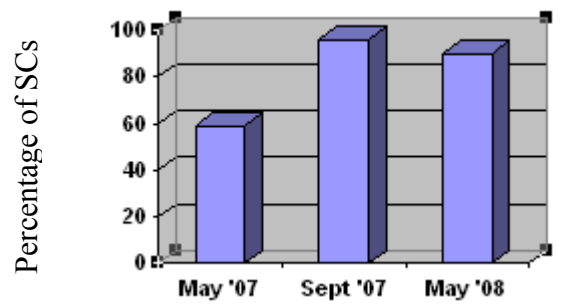
Highlights from pre – post survey results:

Survey instructions: *Please choose one answer for each question that most closely describes your work behavior or experience.*

**Survey Question:** *“I feel that I have the necessary training to screen residents for depression and other mental illnesses.”*

At baseline / Pre Training (May 2007), **59%** of service coordinators said that they either agree or strongly agree with this statement. At Training 5 (Sept 2007), **96%** agreed or strongly agreed, and at Post Training (May 2008), **90%** agreed or disagreed to this statement. See table 1:

Table 1: *“I feel that I have the necessary training to screen residents for depression and other mental illnesses.”*



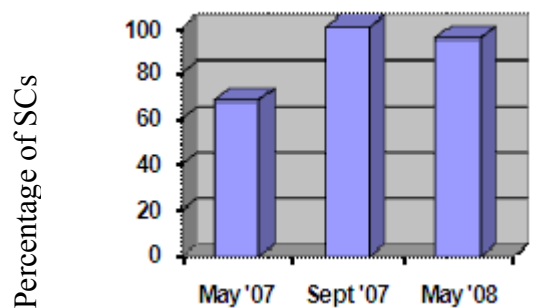
The differences from both baseline (May 2007) to mid-year (September 2007) as well as from baseline to post-training (May 2008) are both statistically significant ( $p = .000$ ) with very good retention of the desired behavior. Despite the 6% reduction in confidence level with depression screening, the fact that 90% of the training participants remain

highly confident about their skill level indicates an ongoing comfort with the material.

Survey Question: *“I feel comfortable communicating with residents’ doctors/clinicians regarding residents’ depression symptoms.”*

At the start of this initiative, 59% of service coordinators either agreed or strongly agreed that they felt comfortable communicating with resident’s health care providers regarding their residents’ symptoms. The Fuqua Center staff encouraged advocating for residents, making appropriate referrals and using the Geriatric Depression Scale as a communication tool when making a referral to a health care provider. At the completion of the year-long project, 95% of service coordinators agreed or strongly agreed that they felt comfortable communicating with residents’ health care providers regarding mental health. We feel that this may have been the result of increased knowledge of depression as well as the possible feeling of knowing the appropriate language to use. For example, instead of noting that “Ms. Smith is depressed,” the SCs are now equipped with being able to report Ms. Smith’s specific depressive symptoms as well as the GDS score. See table 2.

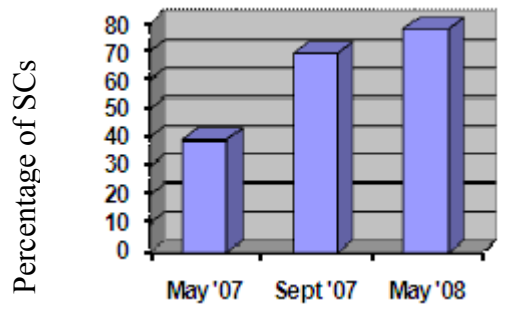
Table 2: *“I feel comfortable communicating with residents’ doctors/clinicians regarding residents’ depression symptoms.”*



**Survey Question: “Overall, I believe my knowledge of suicide, its causes and prevention is....”**

**...“Good” or “Excellent”**

Table 3



At baseline (May 2007), **39%** of SCs felt that their knowledge of suicide, its causes and prevention was good or excellent. At mid-training (in September 2007 after the 5<sup>th</sup> and last face-to-face training), **69%** of SCs felt their knowledge was good or excellent. When surveyed in May 2008 at the completion of the year-long program, **75%** of SCs self-reported that their knowledge was good or excellent.

As previously mentioned, SCs also took same day pre/post surveys for the QPR (Question, Persuade, Refer) which took place on August 8, 2007. The following are some highlights from those surveys:

- Knowledge of how to ask someone about suicide: “high”
  - Pre: **21.7%**
  - Post: **87%**
  
- Level of understanding about suicide and suicide prevention: “high”

- Pre: **8.3%**
- Post: **87%**

Other information gleaned from this survey included the following facts:

- 73% of SCs have personally known someone to commit suicide
- 10 SCs have been involved in the assessment of someone who made a suicide attempt in the last 12 months (May 2008)

Focus Group with Service Coordinators:

Information obtained from the informal focus group conducted with self-selected SCs in August 2007 was helpful in determining barriers to care. Themes and overarching patterns regarding challenges that the SCs face included:

- Need for in-home services (psychiatric evaluation and follow-up)
- Lack of knowledge regarding insurance coverage of mental health services, residents are underinsured and unable to pay co-pays.
- Residents need care but do not necessarily want it
- Stigma associated with depression and mental illness
- Residents unable or unwilling to comply with recommended treatment plan

Telephone surveys:

A graduate student with the University of Georgia's School of Social Work conducted telephone surveys with **25** service coordinators and **10** administrators of senior living communities in April and May 2007. Patterns and overarching themes from the service coordinator surveys are as follows:

- Overall knowledge of depression in older adults has improved / expanded; most service coordinators are more aware of signs and symptoms of depression
  - Those whose knowledge did not expand already had a mental health background
- SCs reported that they are more apt now to ask questions and refer to MH resource
- All but one SC said they feel “better equipped” to deal with residents who may have MH symptoms
  - More comfortable
  - “I’m not as scared or intimidated”
  - SCs feel they now have:
    - More tools (scales/screening tools, educational materials)
    - More support and resources
    - An increase in confidence dealing with mental health
- Gaps or barriers
  - Need for resources / therapists
  - Residents do not acknowledge problem: STIGMA
  - Transportation to appointments
  - Secondary insurance / financial resources
  - Families of residents “in denial” that their loved one is in need of care

Note: The findings from the service coordinator surveys are consistent with the findings from the August 2007 informal focus group.

The following are some themes and patterns gleaned from the facility administrator telephone surveys from May 2008:

- Mental health seems “less taboo” in facilities
- Service coordinators seem more comfortable with the topic of mental health
- There have not been any new formalized or official policies or protocols implemented concerning mental health or suicide. One explanation is that this was a practice-focused intervention with service coordinators rather than one directed to management or administration.

### **Summary**

Overall, the survey results indicate that the service coordinators have an increased knowledge in depression, suicide and general mental health in older adults. Despite this, SCs still report a lack of referral resources as well as other barriers to treatment such as financial assistance for copayments, transportation and stigma. Over a ten-month period, service coordinators expanded their comfort level and familiarity with mental health issues among their resident populations. It can be surmised that the greater level of awareness and familiarity with depression screening heightened the service coordinators’ recognition of the lack of resources for mental health care.

### **Project Limitations**

The following are limitations to the Fuqua / GAHSA Mental Health project:

The surveys obtained regarding attitudes and behaviors are all self-reported. Observed behavior is not available in regards with mental health. Additionally, there is no information available regarding the number of depression screenings or mental health referrals made pre and post training in each facility.

## **References**

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Garand L. Mitchell AM. Dietrick A. Hijjawi SP. Pan D. Suicide in older adults: nursing assessment of suicide risk. *Issues in Mental Health Nursing*. 27(4):355-70, 2006 May.

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**APPENDIX A**  
**STAKEHOLDERS' WORKSHEET**  
**GAHSA MENTAL HEALTH PROJECT**

<b>WHO ARE THE STAKEHOLDERS?</b>	<b>HOW MIGHT THEY USE OR BE AFFECTED BY THE RESULTS?</b>	<b>WHAT ARE THEIR EVALUATION QUESTIONS?</b>
<p><b>Primary stakeholders</b>  The Fuqua Center for Late-Life Depression of Emory University</p> <p>Georgia Association on Homes and Services for the Aging (GAHSA) / Georgia Institute on Aging (GIA) - partner and funding agency</p> <p>American Association on Homes and Services for the Aging (AAHSA) --the nationwide organization</p> <p>Residents of 16 Residential Facilities</p> <p>Service Coordinators</p>	<ul style="list-style-type: none"> <li>- Responsible for the training of 25 SCs in the depression focusing on older adults</li> <li>-SCs change in knowledge, attitudes and behavior on suicide prevention</li> <li>-Residents affected by staff equipped with skills for earlier recognition of suicidal ideation and access to mental health assessment/treatment for those whose at elevated risk</li> <li>- Employ staff in facilities specifically trained in depression and suicide prevention</li> <li>- Fuqua Center presents model of training to be used in Assisted Living Facilities nationwide</li> <li>- Access to SCs well equipped to recognize suicidal ideations and effectively intervene</li> <li>- Decreased risk of suicide success</li> </ul>	<ul style="list-style-type: none"> <li>- Have the SCs been trained?</li> <li>- Have the knowledge, attitudes and behavior of the SCs changed with regards to depression and suicide prevention?</li> <li>- Does this training promote a change of culture in the facilities and improve access to psychiatric services?</li> <li>-Does trained staff feel better equipped to recognize depression and intervene when faced with suicidal ideations? <ul style="list-style-type: none"> <li>- Does trained staff exhibit correct follow through with such situations?</li> </ul> </li> <li>- Were the five face-to-face trainings and six case conferences conducted?</li> <li>- Can this training be implemented nationwide? <ul style="list-style-type: none"> <li>- What were the activities?</li> <li>- What, specifically, was implemented?</li> <li>- What were the short-, immediate- and long-term outputs?</li> </ul> </li> <li>- Have the SCs been given the needed skills to recognize suicidal ideations and intervene effectively?</li> <li>- Will these interventions decrease the potential risk of completed suicide?</li> </ul>

\*SC - Service Coordinator

\*\*QPR – Question/Persuade/Refer

**APPENDIX A**  
**STAKEHOLDERS' WORKSHEET**  
**GAHSA MENTAL HEALTH PROJECT**

<p><b>Secondary stakeholders</b></p> <p>Resident administrators and staff at independent and assisted living facilities / retirement communities</p> <p>Extended family of residents</p>	<p>- Employ staff in facilities specifically trained in suicide prevention</p> <p>- Lower risk of completed suicide among residents living target facilities</p> <p>- Family member(s) living in facility with staff trained to recognize and intervene with suicidal ideations</p> <p>- Is the life of the resident prolonged?</p>	<p>- Have the SCs been trained?</p> <p>- Does trained staff feel better equipped to recognize and intervene when faced with suicidal ideations?</p> <p>- Does the QPR training translate to use with a geriatric population?</p> <p>- Are the staff sufficiently trained to recognize and intervene when a residential, geriatric family member exhibits signs of suicidal ideation?</p> <p>- Is the life of the resident prolonged?</p>
<p><b>Primary Users</b></p> <p>Service Coordinators  Facility Administrators  Fuqua Center</p>	<p>- SCs change in knowledge, attitudes and behavior on suicide prevention</p> <p>- Equipped with useful tools - and the knowledge of how to use them - to prevent suicide in geriatric residents</p>	<p>- Have SCs improved knowledge, attitudes and behavior on depression suicide prevention?</p> <p>- Do SCs have useful tools to use when interacting with an individual with depression and/or suicidal ideations?</p> <p>- Do SCs feel confident utilizing these tools?</p>

Adapted from: Preskill & Russ-Eft (2005) *72 Activities for Teaching and Training*. Sage Publications; Thousand Oaks, CA.

\*SC - Service Coordinator

\*\*QPR – Question/Persuade/Refer

**APPENDIX B  
LOGIC MODEL  
GAHSA SUICIDE PREVENTION PROJECT**

INPUTS	EARLY ACTIVITIES	INTERMEDIATE ACTIVITIES	OUTPUTS	EARLY OUTCOMES	INTERMEDIATE OUTCOMES	IMPACT
<ul style="list-style-type: none"> <li>- Identified need to address Service Coordinators' knowledge, attitudes and behavior on depression and suicide prevention</li> <li>- Authority to train Service Coordinators</li> <li>- Work time allotted for Fuqua Center staff and Service Coordinators to participate in training</li> <li>- Fuqua Center staff, trained in QPR technique</li> <li>- Funds to purchase training materials</li> </ul>	<ul style="list-style-type: none"> <li>-Identify participants</li> <li>-Schedule Training</li> <li>- Develop training (Modify QPR to be geriatric-specific)</li> </ul>	<ul style="list-style-type: none"> <li>-Conduct pre-training test with identified SCs</li> <li>-Train Service Coordinators in QPR Gatekeeper Training</li> <li>-Conduct post-training test with identified SCs</li> <li>-Focus group conducted 3 months post training</li> </ul>	<ul style="list-style-type: none"> <li>-Written educational material posted in facility</li> <li>-Development of email listserv</li> <li>-Identified SCs</li> <li>- Five 2-hour trainings completed for 25 Service Coordinators from 16 residential facilities</li> <li>-25 SCs have knowledge regarding mental health and use QPR techniques in 16 residential facilities</li> <li>- Geriatric-specific QPR Gatekeeper training</li> </ul>	<ul style="list-style-type: none"> <li>-Earlier recognition of depression and suicidal behavior and access to mental health assessment/treatment for those at elevated risk</li> <li>-Increased screening for depression / suicide in the facilities</li> </ul>	<ul style="list-style-type: none"> <li>- Trained Service Coordinators exhibit an increase in skills to recognize depression, assess suicidal behavior and to implement prevention protocol</li> <li>- SC Attitudes change regarding suicidal behavior</li> </ul>	<ul style="list-style-type: none"> <li>-Decreased depressive symptoms and suicide rate in elderly residents in the 16 residential facilities with trained staff</li> </ul>

## *APPENDIX C*

### *GATHERING CREDIBLE EVIDENCE*

<b>EVALUATION QUESTION</b>	<b>POTENTIAL DATA SOURCES</b>	<b>POTENTIAL DATA COLLECTION METHODS</b>	<b>STRENGTHS/DRAWBACKS</b>
1. Have Service Coordinators (SCs) been trained?	Training sign in sheet	Archival Data	S – Accurate, direct, objective D – Sheet could get lost
2. Have the knowledge, attitudes and behavior of the SCs changed with regards to suicide prevention?	Adapted QPR Gatekeeper pre- and post-test Notes from focus group discussion	Test Focus Group	S – Provide immediate feedback D – Subjective, self-rated
3. Does the training promote a change in culture in the facilities and improve access to psychiatric services?	Review of psychiatric services referral log	Archival Data	S – Accurate, direct, objective D – Log could be missing
4. Does the trained staff feel better equipped to recognize and intervene when faced with suicidal ideations?	Adapted QPR Gatekeeper pre- and post-test Notes from focus group discussion	Test Focus Group	S – Provide immediate feedback D – Subjective, self-rated
5. Does such staff exhibit correct follow through with such situations?	Phone survey with ALF Administrators	Phone Survey	S – Accurate, direct, objective D – Log could be missing
6. Was the QPR presentation conducted?	Training sign in sheet	Archival Data	S – Accurate, direct, objective D – Sheet could get lost
7. Can this training be implemented nationwide?	Discussion with AAHSA admin.	Phone Survey	S – Important information D – Multi-factorial questionnaire

## *APPENDIX C*

### *GATHERING CREDIBLE EVIDENCE*

7a. What were the activities (of the training)? 7b. What, specifically, was implemented?	QPR training program	Archival Data	S – Direct, objective D – Could be time-consuming
7c. What were the short-, intermediate- and long-term outputs?	Logic Model	Archival data	S – Objective D – Only one "level" for outputs in logic model
8. Have the SCs been given the needed skills to recognize suicidal ideations and intervene effectively?	Adapted QPR Gatekeeper pre- and post-test Notes from focus group discussion	Test Focus Group	S – Provide immediate feedback D – Subjective, self-rated
9. Will these interventions decrease the potential risk of completed suicide?	QPR Institute stats	Archival Data	S – Available D – Biased, from QPR
10. Does the QPR training translate to use with a geriatric population?	Adapted QPR Gatekeeper pre- and post-test Notes from focus group discussion	Test Focus Group	S – Provide immediate feedback D – Subjective, self-rated
11. Are the staff sufficiently trained to recognize and intervene when a residential, geriatric family member exhibits signs of suicidal ideation?	Adapted QPR Gatekeeper pre- and post-test Notes from focus group discussion	Test Focus Group	S – Provide immediate feedback D – Subjective, self-rated
12. Is the life of the resident prolonged?	Mortality data from ALF?	Archival Data	S – Compelling information D – Could take a long time to recognize effect
14. Do SCs have useful tools to use when interacting with an individual	Adapted QPR Gatekeeper pre- and	Test Focus Group	S – Provide immediate feedback D – Subjective, self-rated

***APPENDIX C***

***GATHERING CREDIBLE EVIDENCE***

with suicidal ideation?	post-test Notes from focus group discussion		
14a. Do SCs feel confident utilizing these tools?	pre- and post-tests, Notes from focus group discussion	Test Focus Group	S – Provide immediate feedback D – Subjective, self-rated

*APPENDIX D*

*PRE- POST-TEST*

**Promotion of Early Detection of Depression and Other Mental Illnesses**

**Service Coordinator Survey**

Today's date: \_\_\_\_\_  
\_\_\_\_\_

ID#

**Demographic information (*Circle appropriate answer*)**

Gender: Male Female Age Range: 18-24 25-34 35-45 50-65 65+

Race: Caucasian African American Hispanic Asian Other

Highest Level of Education Completed: Associates Bachelors Masters Other

What was your education training? Social Work Psychology Other

How long have you worked with your facility?

Less than 2 years 2-5 years 5-10 years Greater than 10 years

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***Please choose one answer for each question that most closely describes your work behavior or experience.***

1. I feel that I have the necessary training to screen clients for depression and other mental illnesses.

- (1) Strongly Agree
- (2) Agree
- (3) Neither
- (4) Disagree
- (5) Strongly Disagree

## *APPENDIX D*

### *PRE- POST-TEST*

2. Do you currently use any screening tools which assess for symptoms of mental illnesses

(e.g., memory problems, depression, mania, psychosis)?

- (1) Always
- (2) Frequently
- (3) Occasionally
- (4) Never

If so, which tools?

3. Screening for depression and other mental illnesses is an appropriate responsibility of

service coordinators.

- (1) Strongly Agree
- (2) Agree
- (3) Neither
- (4) Disagree
- (5) Strongly Disagree

4. I feel comfortable communicating with my clients' doctors/clinicians about my clients' symptoms of mental illness.

- (1) Strongly Agree
- (2) Agree
- (3) Neither
- (4) Disagree
- (5) Strongly Disagree

5. I find it difficult to work with my clients' medical providers.

- (1) Strongly Agree
- (2) Agree
- (3) Neither
- (4) Disagree
- (5) Strongly Disagree

6. If you do *not* refer clients for evaluation of psychiatric symptoms is it because:

- (1) I don't think it is my responsibility to intervene in clients' mental health care
- (2) I am uncomfortable with screening for mental illness
- (3) Screening for depression is too labor intensive

## ***APPENDIX D***

### ***PRE- POST-TEST***

- (4) I don't know where to refer clients who need an evaluation/treatment for mental illness
- (5) There aren't any referral resources available
- (6) Lack of transportation for the client
- (7) Clients refuse to seek or follow through with treatment of his/her psychiatric symptoms

7. When I have referred a client for further evaluation or treatment for depression or other

mental illness, I have seen an improvement in their symptoms.

- (1) Strongly Agree
- (2) Agree
- (3) Neither
- (4) Disagree
- (5) Strongly Disagree
- (6) I have not referred any clients for an evaluation

***APPENDIX D***

***PRE- POST-TEST***

8. I feel comfortable using the Fuqua Center staff as a resource if I have questions regarding the care of persons with depression or regarding referral resources.

- (1) Strongly Agree
- (2) Agree
- (3) Neither/Not sure
- (4) Disagree
- (5) Strongly Disagree

9. Do you think knowing more about the following would be helpful to you in caring out your job responsibilities?

- Knowing how to screen for depression YES NO
- Knowing how to screen for suicidal ideation YES NO
- Becoming more familiar with treatment options for depression YES NO
- Knowing how to monitor treatment effectiveness YES NO
- Being more familiar with the mental health resources in your region YES NO

10. Is there someone in your organization that you see as a resource to you in caring for clients with mental illness? YES NO If so, who is it?

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11. Is there an agency or professional outside your organization that you see as a resource to you in caring for your clients with mental illness? YES NO If so, who is it?

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12. Are there Mental Health resources and/or Mental Health Services you would like to learn about?

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## *APPENDIX D*

### *PRE- POST-TEST*

- 
13. Which age group has the highest percentage of completed suicides in Georgia?
    - a. 65+
    - b. 13-17
    - c. 25-34
    - d. 45-54
  
  14. What is the number one cause of suicide?
    - a. Untreated major depressive disorder
    - b. Acute and severe stress
    - c. Rejection by a loved one
    - d. Alcoholism, especially if the person has recently been diagnosed with a terminal illness
  
  15. If you intercept a suspected suicidal communication (clue, warning sign, suspicious statement or threat), which of the following questions should be avoided?
    - a. You're not thinking of killing yourself, are you?
    - b. Are you thinking about suicide?
    - c. Are you feeling so bad you'd like to go to sleep and never wake up?
    - d. Have you ever wished you were dead?
  
  16. The most commonly identified psychological state of those who take their own lives has been found to be:
    - a. Hallucinations
    - b. Sadness
    - c. Anger
    - d. Humiliation
    - e. Hopelessness
  
  17. Asking a distressed person if s/he is having thoughts of death or suicide:
    - a. Should never be done, as it may put the idea of suicide in the person's mind
    - b. Should only be done by professionally trained persons.
    - c. May lower the risk of suicide
    - d. Should have no effect on the risk of suicide
  
  18. Which of these is *not* a symptom of depression?
    - a. Anxiety
    - b. GI problems (constipation or diarrhea)
    - c. Physical pain
    - d. None of the above

## ***APPENDIX D***

### ***PRE- POST-TEST***

19. Half of older adults who are depressed obtain treatment.
  - a. True
  - b. False
  
20. The majority of older adults who do seek treatment are treated by a:
  - a. psychologist
  - b. psychiatrist
  - c. social worker
  - d. primary care physician
  
21. The \_\_\_\_\_ screening tool should be administered to screen for depression in a person with dementia.
  - a. Beck Depression Inventory
  - b. Geriatric Depression Scale
  - c. Cornell Scale
  - d. Patient Health Questionnaire - 9
  
22. The most appropriate form of psychotherapy for older adults with depression is usually:
  - a. Psychoanalytic based psychotherapy
  - b. Cognitive behavioral therapy
  - c. Aversion therapy
  - d. Milieu therapy
  
23. Choose the type of treatment for depression that is *not* used in older adults.
  - a. Medication
  - b. Psychotherapy
  - c. Electroconvulsive Therapy
  - d. All of the above can be used appropriately.
  
24. Which of the following puts an older adult at risk of depression:
  - a. Alzheimer's disease
  - b. Cardiovascular disease
  - c. Diabetes
  - d. History of cancer
  - e. All of the above
  
25. Older adults can exhibit psychotic features with:
  - f. Dementia
  - g. Depression

## ***APPENDIX D***

### ***PRE- POST-TEST***

- h. Bipolar disorder
- i. Delirium
- j. All of the above

#### **Knowledge and Skill Survey<sup>1</sup>**

1. In your role as a *professional*, have you ever suspected and/or intercepted a suicidal communication or seen one or more warning signs in someone to whom you were providing service?

Yes \_\_\_\_\_ No \_\_\_\_\_

1a. If yes, how many suicidal persons have you identified/encountered in the past 12 months?

\_\_\_\_\_

1b. Did any of them attempt suicide? Yes \_\_\_\_\_ No \_\_\_\_\_ How many? \_\_\_\_\_ How many died? \_\_\_\_\_

Comments:

2. In your role as a *citizen (non-professional life)* have you ever suspected and/or intercepted a suicidal communication or seen one or more warning signs of suicide?  
Yes \_\_\_\_\_ No \_\_\_\_\_

2a. If yes, how many suicidal persons have you identified in the past 12 months? \_\_\_\_\_

2b. Did any of them attempt suicide? Yes \_\_\_\_\_ No \_\_\_\_\_ How many? \_\_\_\_\_ How many died? \_\_\_\_\_

Comments:

3. As a professional, have you been involved in the *assessment* of someone who made a suicide attempt?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many in the past 12 months? \_\_\_\_\_

Comments:

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<sup>1</sup> Adapted from *Professional Suicide Knowledge and Skill Survey*, QPR Institute, [www.qprinstitute.com](http://www.qprinstitute.com)

**APPENDIX D**

**PRE- POST-TEST**

4. Have you personally known anyone who ended his or her life by suicide?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, was this person or these persons a (circle one or more letters)?  
a. Blood relative/family member (number \_\_\_\_\_)  
b. Friend(s) (number \_\_\_\_\_)  
c. Consumer of my professional services (number \_\_\_\_\_)
5. When confronted with a potentially suicidal consumer of your services, did you make some attempt to intervene?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Can't recall \_\_\_\_\_ Didn't know what to do / did nothing \_\_\_\_\_
6. If you did attempt an intervention, please indicate how you felt while handling the crisis:
- |                         |   |   |   |                           |
|-------------------------|---|---|---|---------------------------|
| 1                       | 2 | 3 | 4 | 5                         |
| <i>Very comfortable</i> |   |   |   | <i>Very uncomfortable</i> |
- I felt:
- |                       |   |   |   |                         |
|-----------------------|---|---|---|-------------------------|
| 1                     | 2 | 3 | 4 | 5                       |
| <i>Very competent</i> |   |   |   | <i>Very incompetent</i> |
7. Overall, I believe my knowledge of suicide, it's causes and prevention is (circle one):  
a. Poor  
b. Fair  
c. Good  
d. Excellent
8. For persons in my position, education in suicide risk detection, initial assessment and referral skills:  
Are not necessary \_\_\_\_\_ Necessary \_\_\_\_\_ Should be required \_\_\_\_\_
9. In my professional role, I believe I have some duty to assist suicidal persons and consumers of my services and, therefore, some exposure to legal action if I fail to take reasonable and prudent steps to reduce the risk of a suicide attempt or completion.  
Yes \_\_\_\_\_ No \_\_\_\_\_

*APPENDIX D*

*PRE- POST-TEST*

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**Thank you for taking time to complete this survey! ☺**

## ***APPENDIX E***

### ***SERVICE COORDINATOR PHONE SURVEY GUIDE***

#### **Introduction:**

***Would you feel comfortable about answering some questions about the depression education training that you've been involved with through the Fuqua Center, GAHA and the Georgia Institute on Aging? Just as a reminder, the training focused on the following areas:***

- ***Recognition of symptoms***
- ***How to screen for depression, dementia and suicide ideation***
- ***Possible referral sources***
- ***Medication and treatment options***

***All information you provide will be confidential. No names will be used in the evaluation write up.***

Q1. Since the training, how has your knowledge regarding depression and suicide prevention changed?

Q2. Has your **attitude** toward depression and suicide prevention changed? *If yes, please describe.*

Q3. How have these changes impacted the way you work with the residents in your building?

Q4. Have these trainings incorporated a change in culture in your facility? *If yes, please describe.*

Q5. Do you feel better equipped to recognize and work with residents who may be depressed or anxious? *If yes, please explain how.*

## ***APPENDIX E***

### ***SERVICE COORDINATOR PHONE SURVEY GUIDE***

Q6. How has your level of confidence changed when interacting with a resident who demonstrates signs and symptoms of suicide?

- A. More confident
- B. Less confident
- C. No change

Q7. How would you describe the fit of the QPR Gatekeeper Training with a geriatric population?

Q8. Please comment on any gaps in care or any other barriers you feel you face when you encounter a resident with depressive symptoms.

***The following questions are meant to provide suggestions for other service coordinators:***

Q8. How have you managed to incorporate what you learned into your regular workflow?

Q9. What are your suggestions regarding the best ways to train others around the state regarding this topic?

Q11. Any other feedback regarding the training or how you're using it in your community?

## *APPENDIX F*

### *PHONE SURVEY (ALF ADMINISTRATORS)*

#### *Facility Administrator Phone Survey Guide*

##### **Introduction**

**Since last May, the service coordinators in your facility have participated in a GAHSA/Georgia Institute on Aging sponsored training with staff from the Fuqua Center for Late-Life Depression. Fuqua Center staff held trainings on depression in older adults. The training provided your service coordinators with skills and techniques for interacting with a resident who is demonstrating the signs of depression and other mental illnesses. May I ask you some questions about your impression of changes in your service coordination staff and residents since that training?**

Q1. How has the comfort level of the service coordinators changed when discussing mental illness or suicide since the training?

Q2. Do you see a change in the level of awareness of depression or suicide in your facility since the training? Please describe.

Q3. How do you feel the "culture" in your facility, with regards toward depression and suicide, has changed?

Q4. Describe any protocols or policy changes that have been implemented in your organization as a result of the Fuqua Training.

Q5. Do you have any other comments regarding the training, your service coordinators' behavior, or the culture in your facility regarding suicide?

Thank you for your time. Please feel free to contact me with any other comments you might have.

## APPENDIX I

### Original Project Objectives May 2007

#### Same Day Survey outcomes: GAHSA QPR Suicide Gatekeeper Training (August 8, 2007)

##### Knowledge of facts concerning suicide prevention:

Pre:	Post:
Low: 21.7%	Low: 0%
Medium: 69.6%	Medium: 30.4%
High: 8.7%	High: 69.6%

##### Knowledge of warnings signs of suicide:

Pre:	Post:
Low: 4.3%	Low: 0%
Medium: 73.9%	Medium: 17.4%
High: 21.7%	High: 82.6%

##### Knowledge of how to ask someone about suicide:

Pre:	Post:
Low: 30.4%	Low: 0%
Medium: 47.8%	Medium: 13%
High: 21.7%	High: 87%

##### Knowledge of how to persuade someone to get help:

Pre:	Post:
Low: 21.7%	Low: 4.5%
Medium: 56.5%	Medium: 18.2%
High: 21.7%	High: 77.3%

##### Knowledge of how to get help for someone:

Pre:	Post:
Low: 8.7%	Low: 0%
Medium: 56.5%	Medium: 17.4%
High: 34.8%	High: 82.6%

## APPENDIX I

### Original Project Objectives May 2007

#### *Knowledge about local resources for help with suicide:*

<b>Pre:</b>	<b>Post:</b>
Low: 39.1%	Low: 4.3%
Medium: 43.5%	Medium: 34.8%
High: 17.4%	High: 60.9%

#### *Do you feel that asking someone about suicide is appropriate?*

<b>Pre:</b>	<b>Post:</b>
Always: 34.8%	Always: 82.6%
Sometimes: 65.2%	Sometimes: 17.4%
Never: 0%	Never: 0%

#### *Do you feel likely to ask someone if they are thinking about suicide?*

<b>Pre:</b>	<b>Post:</b>
Always: 30%	Always: 82.6%
Sometimes: 69.6%	Sometimes: 17.4%
Never: 0%	Never: 0%

#### *Please rate your level of understanding about suicide and suicide prevention:*

<b>Pre:</b>	<b>Post:</b>
Low: 17.4%	Low: 0%
Medium: 73.9%	Medium: 13%
High: 8.3%	High: 87%

#### *Please provide your overall rating of the quality of the training:*

Excellent:	21.7%
Very Good:	65.2%
Good:	4.3%
Fair:	8.7%
Poor:	0%

#### *Would you recommend QPR training to others?*

Yes:	87%
No:	4%
Undecided:	8.7%

## ***APPENDIX I***

### ***Original Project Objectives May 2007***

#### ***Verbatim Comments:***

- *Extremely helpful information - gave me more confidence in asking the right questions.*
- *This is a training that everyone should go through because you never know when someone could use your assistance in this matter.*
- *The training was informative and useful; especially QPR training. Keep up the good work!*
- *Very good training.*
- *The training was very informative. Need more breaks and more interational tasks.*
- *It's important to stress the roles of non-professionals in suicide prevention.*
- *Nancy (ie) is very knowledgeable and presented the material excellent. I feel a lot more educated on the topic with this training.*

## ***APPENDIX I***

### ***Original Project Objectives May 2007***

#### **GAHSA / GIA Mental Health Project Training objectives**

##### **Training 1: Recognizing Depression**

Objectives:

- 1.) Improve understanding of depression and other mental illnesses in older adults
- 2.) Gain knowledge of prevalence of depression in older adults
- 3.) Understand the differences and similarities in depression and other medical illnesses in older adults

##### **Training 2: Screening for depression**

Objectives:

- 1.) Learn about the different screening tools that are shown to be valid and reliable
- 2.) Learn how to use these tools (administer and score) in order to improve ability to screen for depression
- 3.) Learn how to document and communicate findings

##### **Training 3: Treatment Options**

Objectives:

- 1.) Learn treatment options for depression in older adults
- 2.) Identify antidepressants and other psychopharmacological medications
- 3.) Learn to monitor effectiveness of these treatments

##### **Training 4: Making Appropriate Referrals**

Objectives:

- 1.) Learn the types of resources for mental illness
- 2.) Learn about appropriate types of referrals when imminent risk and non-imminent risk is present
- 3.) Discuss local resources in order to enhance ability to identify community resources for older adults with mental illness

##### **Training 5: Dementia, Depression and Suicidal Ideation**

- 1.) Discuss use of screening tools for depression in dementia
- 2.) Learn to identify / assess suicidal ideation
- 3.) What to do with a suicidal client?