ABSTRACT

HOME-BASED MENTAL HEALTH SERVICES FOR LATINO OLDER ADULTS:

A GRANT PROPOSAL

By

Kathleen Keilman

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The purpose of this project was to locate a potential funding source and write a grant to provide home-based mental health services to Latino older adults for Beach Cities Health District, in Redondo Beach, California, the host agency for this program. An extensive literature review was conducted to investigate the best way to provide non-traditional therapeutic services to older adults. The Archstone Foundation was chosen as the most appropriate funding source.

The population of Latino older adults is expected to grow significantly in the coming years. Many in this population suffer from depression but fail to access services due to language barriers and other obstacles. This program was developed to improve knowledge of depression and improve coping skills, as well as reduce symptoms of depression.

If funded, this program could provide social workers an opportunity to bridge the gap the need for and the receipt of mental health services among older Latinos. Submission of the grant was not a requirement for the thesis project.

HOME-BASED MENTAL HEALTH SERVICES FOR LATINO OLDER ADULTS: A GRANT PROPOSAL

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Committee Members:

Marilyn Potts, Ph.D. (Chair)
Jo Brocato, Ph.D.
Molly Ranney, Ph.D.

College Designee:

Nancy Meyer-Adams, Ph.D.

By Kathleen Keilman

B.A., 2007, University of California, Davis

January 2015

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

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shaped me into the person I am and continue to be the standard to which I hold myself to every day. Thank you for watching over me.

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CHAPTER 1

INTRODUCTION

The older adult population in the United States continues to grow at a significant rate, with the Administration on Aging estimating that there will be 72.1 million older adults by the year 2030 (U.S. Department of Health and Human Services, 2014). Older adults typically experience several unique challenges specific to the aging process. Many experience an increase in health issues, loss of independence, and overall changes in the routines of daily life (Coyle & Dugan, 2012). Although some older adults navigate through these challenges successfully, many struggle with the effects of these changes, causing some individuals to struggle with mental health challenges or augmenting already existing issues (B. G. Knight & Sayegh, 2011). Depression is a significant issue among the older adult population, as depressive symptoms can be connected to a reduction in the ability to function socially, increased physical ailments and disabilities, and diminished cognitive functioning (M. Knight & Houseman, 2008; Maxfield & Segal, 2008). Furthermore, older adults have a higher probability of dying as result of suicide when compared to their younger counterparts (Corcoran, Brown, Davis, Pineda, Kadolph, & Bell, 2013).

Within the United States, it is estimated that among the 20% of older adults who struggle with mental health issues, only half are receiving some sort of mental health support (Bruce, Van Citters, & Bartels, 2005; Solway, Estes, Goldberg, & Berry, 2010).

Older adults face several obstacles when seeking services for mental health concerns. Many are unaware of services available to them, some are unwilling to ask for help, and others are unaware that their symptoms are indicative of a larger problem (Choi, Kunik, & Wilson, 2013). Many older adults who struggle with depression go undiagnosed, as many times depressive symptoms manifest themselves as physical ailments and not as obvious behavioral changes (Corcoran et al., 2013).

Ethnic minority groups among the older adult population also experience certain challenges when attempting to access mental health services. The Latino population in the United States is by far the largest and most rapidly growing ethnic minority group; however, they are significantly underutilizing mental health services, particularly with respect to depression (Chavez-Korell et al., 2012). The lack of services being accessed can be attributed to several factors such as stigma, language barriers, and lack of cultural competence and sensitivity (Jimenez, Bartels, Cardenas, & Alegría, 2013). Understanding these issues and incorporating ways to address them into available services is imperative in providing effective services to this population.

Although there are mental health services available to older adults, in order to overcome the barriers that affect the accessibility of services, non-traditional approaches to mental health support are being explored (Bruce et al., 2005). Home-based mental health services are a resource that can provide case management, assessment, and therapeutic interventions in the home of the client. This type of service assists older adults who are unable or unwilling to access resources due to lack of transportation, fear of stigma, or health concerns (Kohn, Goldsmith, Sedgwick, & Markowitz, 2004; Yang, Garis, Jackson, & McClure, 2009). Furthermore, by incorporating cultural competence

and sensitivity into these services, many ethnic minority older adults can more easily access mental health services.

Statement of Purpose

The purpose of this thesis project was to write a grant for Beach Cities Health District to implement a program to provide Latino older adults with mental health services in the home, in order to assure easier access to appropriate mental health treatment as opposed to more traditional agency-based services. Program services would include a biopsychosocial assessment, therapeutic interventions, and better access and connection to community resources and support.

Definitions of Terms

Depression: "A common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration" (World Health Organization, 2014, para. 1). Severity and length can vary and the condition can be recurrent.

Home-Based Mental Health Services: A non-traditional approach to providing mental health services in the home, which may include a combination of therapeutic treatment, referrals, assessment, and case management (Bruce et al., 2005).

Latino: "A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race" (U.S. Department of Education, 2014, para.2). The words "Latino" and "Hispanic" will be used interchangeably.

Mental Health: "A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and

fruitfully, and is able to make a contribution to her or his community" (World Health Organization, 2014, para.1).

Older Adult: An individual who is 65 years or older (Chavez-Korell et al., 2012).

Multicultural Relevance

By the year 2025, the number of ethnic minority individuals in the United States will account for more than 40% of the overall population (Solway et al., 2010). It is important to be mindful that cultural differences should be explored and taken into consideration when choosing effective interventions for mental health issues. A multicultural focus would be used in the proposed program as the target population consists of Latino older adults, both male and female, diagnosed with depression. Additionally, a qualified bilingual social worker would be hired to implement the program to assist with those older adults who are monolingual or more comfortable communicating in Spanish.

Importance to Social Work

According the National Association of Social Worker's *Code of Ethics*, social workers are expected to be informed about diversity and cultural competence (National Association Social Workers [NASW], 2008). As such, this project has significance for the social work field as it is designed to improve accessibility to services for Latino older adults dealing with mental illness. This is consistent with the social work value of serving disenfranchised and oppressed groups (e.g., the elderly, ethnic minorities, and the mentally ill). This program can also assist older adults to learn appropriate coping strategies and as a result help improve their overall quality of life. By using home-based

mental health services, non-traditional service delivery methods can be explored and implemented to reach larger groups of older adults struggling with mental illness.

CHAPTER 2

LITERATURE REVIEW

According to the U.S. Department of Health and Human Services (2014), during the year 2000 the number of older adults in the United States represented 12.4% of the overall population and by the year 2030 is expected to grow to almost 20%. The continued growth of this population can be attributed to several factors, most importantly the increased longevity of older adults and the fact that large portions of the baby boomer generation are reaching the age of 65 (B. G. Knight & Sayegh, 2011). Through the aging process, older adults can experience significant changes that greatly affect various facets of their lifestyle. Some of these natural transitions are poor mobility or ambulation, loss of friends and family, retirement, and the escalation of health problems and illnesses (Coyle & Dugan, 2012). As a result of these changes, many older adults experience feelings of isolation, loneliness, and a decrease in their social activities. Many of these behavioral changes can contribute to the onset or increased severity of mental health issues, as well as affecting their physical health and their compliance with treatment for physical ailments (B. G. Knight & Sayegh, 2011).

Older Adults and Mental Illness

It is estimated that about 20% of the population of older adults in the United States suffer from mental illness (Bruce et al., 2005; Solway et al., 2010). Mental illness refers to a broad range of behaviors, emotions, and thoughts that make it difficult to have

relationships with others while also affecting the ability to function appropriately in the workplace, at home, and in school settings (Overton & Medina, 2008). Although mental illness affects older adults in many ways, depression is one of the most significant mental health challenges facing this population (M. Knight & Houseman, 2008; Maxfield & Segal, 2008). Among older adults residing within the community, symptoms of depression can range from 8-16% (Chippendale, 2013; Scogin, Moss, Harris, & Presnell, 2013). Additionally, there is a reported higher rate of depression among those older adults living in long-term care facilities such as nursing homes (Chippendale, 2013; M. Knight & Houseman, 2008).

Depression

Depression can be categorized in several different ways. Some types of depression involve intermittent depressive symptoms over varied periods of time, while others fall into more specific categories such as major depressive disorder (MDD) or persistent depressive disorder (Centers for Disease Control and Prevention [CDC], 2014; National Institute of Mental Health, 2014). The National Institute of Mental Health (2014) has reported that about 6.7% of adults in the United States struggle with major depressive disorder, making it one of the most common mental health disorders in the country.

Major depressive disorder is a psychiatric disorder that must meet criteria recognized by the American Psychiatric Association (APA; 2013). In order for a diagnosis of MDD to be given, symptoms must disrupt one's ability to function normally in settings such as work, home, or other social situations that are important in daily functioning (APA, 2013). Included among the criteria recognized by the APA are nine

symptoms, of which at least five must exist over a time frame of 2 weeks and demonstrate a marked change from how the individual was functioning previously (APA, 2013; CDC, 2014). The symptoms for MDD outlined by the APA are as follows: sadness, hopelessness, and depressed mood on a consistent daily basis; disinterest or displeasure in most or all activities that may have previously been favorable; noticeable change in weight, either loss or gain, or significant change in previous appetite; excessive sleeping or insomnia on a daily basis; observable psychomotor delay or agitation; lack of energy or feelings of exhaustion; feelings of guilt and worthlessness that are not appropriate; inability to concentrate and difficulty making decisions; and frequent and repetitive thoughts of death or thoughts of suicide (APA, 2013; CDC, 2014). According to the National Institute of Mental Health (2014), major depressive episodes can occur as a single event in one's lifetime; however, it is more common for a person to have multiple episodes. The CDC (2014) reported that individuals who experience at least one episode of major depression are 50% more likely to have another episode, with each additional episode increasing the possibility of additional episodes.

Persistent depressive disorder, sometimes referred to as dysthymia, is a psychiatric disorder that is defined by experiencing a depressed mood for a significant part of the day, more days than not, that lasts for a period of at least 2 years (APA, 2013; National Institute of Mental Health, 2014). During that time it is common for individuals to have episodes of major depression mixed with periods of depressed mood that do not fully meet the criteria for MDD (APA, 2013; National Institute of Mental Health, 2014). In order for an individual to meet criteria for persistent depressive disorder, as defined in the *Diagnostic Statistical Manual V*, one must have experienced at least two of the

following symptoms: either an increase or decrease in appetite, excessive sleep or insomnia, excessive fatigue or tiredness, poor self-esteem, difficulty with decision making and concentration, and hopelessness (APA, 2013).

Depression in Older Adults

While the APA has delineated specific criteria within the *Diagnostic Statistic Manual* for the aforementioned depressive disorders, many times symptoms of depression in older adults can manifest differently when compared to other age groups (Corcoran et al., 2013; Luijendijk et al., 2008; Scogin et al., 2013). As such, consideration of psychological symptoms in addition to potential somatic symptoms should be taken into consideration (Corcoran et al., 2013; Scogin et al., 2013). It is common for older adults to report physical problems such as tiredness, inability to sleep, significant weight loss, and other physical difficulties instead of unhappiness, helplessness, and other emotional changes that may more clearly indicate depressive symptoms (Corcoran et al., 2013).

In a meta-analysis that compared the phenomenology of depression in older adults to that of their younger counterparts, Hegeman, Kok, Van der Mast, and Giltay (2012) found that older adults with depression tended to report more somatic symptoms than younger adults with depression. Although the rates of depression among older adults are not as high as those among other age groups, they have a higher probability of dying as result of suicide (Chippendale, 2013; Corcoran et al., 2013). In the issue brief, *The State of Mental Health and Aging in America*, the CDC (2008) reported that elderly men have one of the highest suicide rates among all the age groups: "Men aged 85 years or older have a suicide rate of 45.23 per 100,000, compared to an overall rate of 11.01 per

100,000 for all ages" (p. 2). Additionally important to note is that a vast majority of those older adults who committed suicide had made a visit to their physician within the previous month (Chippendale, 2013).

Although frequently held stereotypes indicate that depression and depressive symptoms are a normal aging experience for older adults, depression is not a typical mental health issue for the elderly (M. Knight & Houseman, 2008; Maxfield & Segal, 2008). While many older adults may not meet criteria for a psychiatric disorder such as major depressive disorder, the rate of depressive symptoms experienced by older adults is estimated to be between 15-25% of the population (Maxfield & Segal, 2008). Symptoms of depression in older adults can be connected to the reduction in their ability to function socially and engage with others in a positive manner, increased physical ailments and disabilities, diminished cognitive functioning, and a poor sense of self (M. Knight & Houseman, 2008; Maxfield & Segal, 2008; Steffens et al., 2000). Many times, depressive symptoms are linked to greater levels of physical disability, actual pain in the body, unexplained somatic symptoms, and the need for more bed rest due to those physical problems (B. G. Knight & Sayegh, 2011; M. Knight & Houseman, 2008). In a cross-sectional, two-part epidemiological study that examined the correlation between recurrent visits to a primary care physician and depression in older adult patients, depression increased the likelihood of visiting the primary care physician by fivefold among those individuals who did not have a serious medical condition (Menchetti, Cevenini, De Ronchi, Quartesan, & Berardi, 2006).

A 4-year longitudinal study of 105 older adults ages 75 or older examined whether cognitive impairments and depressive symptoms related to cognitive complaints.

The results demonstrated that higher levels of depressive symptoms were associated with more self-reported cognitive complaints, as well as cognitive impairments observed by others (Hohman, Beason-Held, & Resnick, 2011). Although a potential decline in cognitive functioning is to be expected through the aging process, depression in older adults can cause a more significant decline than what is considered normal (Dotson, Resnick, & Zonderman, 2008). In another longitudinal study that examined the connection between symptoms of depression and the decline of cognitive functioning, 1,586 adults over the age of 50 were assessed every 2 years on average over the span of 26 years. The study found that while higher levels of symptoms of depression were connected with lack of ability to control aspects of the cognitive process or executive function, general depressive symptoms were considered to have the strongest effect on the cognitive process (Dotson et al., 2008).

Decline in the ability to function daily is also considered to have a strong relationship with depression in older adults (M. Knight & Houseman, 2008). Functional decline can be described as "a loss of independence in self-care activities or as a deterioration in self-care skills" (Hoogerduijn, Schuurmans, Duijnstee, de Rooij, & Grypdonck, 2007). The ability of an older adult to function at an appropriate level is important as it helps the elder to remain independent. In a longitudinal study conducted in Japan to examine the connection between decline in function and depression, 710 older adults of both genders participated in a 12-year study (Iwasa et al., 2009). The authors reported two main points in regards to the relationship between cognitive decline and depression. First, "there is an independent relationship between depression status and longitudinal change in functional capacity among community-dwelling older individuals"

and second, as a result it can be assumed that depression can be "reliable predictor of functional decline (both of basic activities of daily living decline and higher-level competence decline) in older individuals" (Iwasa et al., 2009, p. 1199).

Barriers to Older Adults Seeking Mental Health Services

Finding adequate mental health services and accessing treatment are challenges for all individuals, regardless of age (B. G. Knight & Sayegh, 2011). However, with the growing number of older adults in the United States, this particular population has begun and will continue to impact significantly the availability of mental health services and the various systems in which they are delivered (Maxfield & Segal, 2008). Notably, it is estimated that about 20% of the population of older adults in the United States suffer from mental illness, while only half of those who are suffering receive some sort of mental health support (Bruce et al., 2005; Solway et al., 2010). Some of the challenges in providing mental health services to older adults are attributed to poor insight into their problems, resistance to opening up to a trained professional, and fear of mental health stigma (Choi et al., 2013).

Lack of Insight and Awareness of Services

Many older adults are unaware of the need for mental health services to support them. Unfortunately, due to common misconceptions, many older adults who struggle with mental illness are led to believe by family, the general public, and even sometimes those in the health and mental health field that their symptoms are due to common issues related to aging (Chavez-Korell et al., 2012; Karlin, Duffy, & Greaves, 2008). However, struggling with mental health concerns, such as depression, is not a normal part of the aging process and can those who are affected can be supported through a variety of

treatment modalities and services (M. Knight & Houseman, 2008; Maxfield & Segal, 2008).

In addition, older adults often decline to seek services due to the fact that they do not recognize a perceived need to get help for mental health issues (Choi et al., 2013). A study by Mackenzie, Pagura, and Sareen (2010) examined how socio-demographic indicators and overall mental health impacts whether older adults perceived a need to seek services and whether they would actually engage the help of a professional specializing in mental health. This study used the Collaborative Psychiatric Epidemiology Survey and the total number of respondents equaled 20,013. However, for the purposes of this study the focus was placed on those 3,017 respondents over the age of 55. The results showed that older adults (65 years and older) expressed the lowest level of perceived need as opposed to younger adults (those who were 25-44 years old) who reported the highest perceived need. Furthermore, 47.1% of the older adults who had a diagnosed psychiatric disorder did not identify a perceived need to seek assistance from a professional. The study identified that the most significant and common obstacle for those to seek help actively was a desire to deal with their own problems themselves.

When compared to younger age groups, older adults are generally far less likely to attempt to access services (Choi et al., 2013; Karlin et al., 2008; Mackenzie et al., 2010). In addition to having a desire to deal with problems themselves, many older adults have significant resistance to opening up to a trained professional, are fearful of mental illness stigma, and/or have poor insight into their own problems (Choi et al., 2013). Byers, Arean, and Yaffe (2012) studied reasons for the lack of use of mental health services among 348 adults, 55 and older, who had a diagnosed anxiety or mood

disorder for a least a year. The results showed that almost 70% of the participants did not access supportive services. Additionally, those participants who identified as an ethnic minority, struggled with opening up about personal issues, were of middle socioeconomic status, and were living with a partner or married were more likely than other participants to avoid using mental health resources. Furthermore, those individuals who struggled with a more mild disorder, were considered less cognitively impaired, and reported no consistent pain symptoms were also less likely to engage in services (Byers et al., 2012).

Lack of Mental Health Screening in Primary Care Settings

Older adults dealing with a mental health concerns, such as depression, often present with physical symptoms and difficulties instead of behavioral symptoms (Corcoran et al., 2013). As a result, the professional to whom they first reach out to for help is usually their primary care physician (Karlin et al., 2008). Unfortunately, while healthcare providers are able to provide assistance to older adults with mental health concerns, it is common for symptoms of depression to be overlooked in primary care settings (Karlin et al., 2008; M. Knight & Houseman, 2008). Many times, primary care physicians are pressed for time when they are trying to assist older adults with already significant health ailments and thus face the dilemma of balancing the priorities of proper healthcare and mental health support (Chavez-Korell et al., 2012; Karlin et al., 2008). Depressive symptoms in older adults are observed in only 10-25% of cases (M. Knight & Houseman, 2008). In a study that examined whether doctors in a primary care setting were assessing older adults for depression, it was reported that patients were only evaluated for depression 14% of the time (Tai-Seale et al., 2005). Additionally, the study found that European American patients were at least 7 times more likely to be evaluated

for depression compared to minority group patients (Tai-Seale et al., 2005). In some cases, physicians are less likely to refer older adults to therapy services than their younger counterparts (Karlin et al., 2008).

Mobility, Transportation, and Location

When examining barriers that affect access to mental health services for older adults, lack of mobility and transportation issues are significant factors since many are physically unable to provide transportation for themselves or do not have ready access to reliable transportation (Bruce et al., 2005). While mental health services may be available, they are not of value if older adults cannot access them (Solway et al., 2010). Transportation becomes increasingly difficult with age, as many times illness and health ailments may limit the driving ability of older adults or prevent them from driving (Maxfield & Segal, 2008). Furthermore, those who are living in rural areas are a forgotten subgroup within the population of older adults (Scogin et al., 2013). Due to the geographical location of their homes, many older adults are significantly isolated and experience a decline in their social supports, as well as a lack of community and mental health resources (Crowther, Scogin, & Norton, 2010).

Barriers to Latino Older Adults Seeking Mental Health Services

By the year 2025, the number of ethnic minority individuals in the United States will account for more than 40% of the overall population (Solway et al., 2010). Latinos are by far the biggest and most rapidly growing ethnic minority group in the United States (Alvarez, Rengifo, Emrani, & Gallagher-Thompson, 2014). However, the Latino population is significantly underutilizing mental health services, particularly with respect to treatment for depression (Chavez-Korell et al., 2012). There are several challenges

and barriers that face Latino older adults seeking mental health services and in order for this population to be best served, those obstacles must be addressed (Alvarez et al., 2014; Jimenez et al., 2013).

Stigma

The concept of stigma within the context of mental illness can be difficult to understand, let alone define (Overton & Medina, 2008). According to Overton and Medina (2008), stigma takes into account social identity theory, which explores how people use social standards to cast a judgment or label onto individuals who do not fall within the parameters of what is considered appropriate or normal. While stigma is often created by groups outside oneself, self-stigma, defined as casting judgments on oneself, is also a problem (Overton & Medina, 2008). An individual's feelings of inadequacy, shame, and the possibility of disappointing one's family can also be considered an obstacle when attempting to access mental health support (Jang, Chiriboga, Herrera, Tyson, & Schonfeld, 2011).

According to Jimenez et al. (2013), Latino older adults with mental illness struggle with three different types of stigma: their older age itself, their mental health issues, and their minority status. These factors can be significant obstacles in seeking services. In a study by those authors, attitudes about mental health services and mental health in general were examined in diverse ethnic minority groups of older adults struggling with depression, anxiety, and at-risk levels of alcohol intake. Older adults who identified as Latinos, Asian Americans, African Americans, and non-Latino Whites each completed the Mental Health and Alcohol Abuse Stigma Assessment created by the Substance Abuse and Mental Health Services Administration. The results of the study

indicated that Latinos and African Americans felt more at ease when communicating with their primary care doctor compared to Asian Americans and non-Latino Whites. However, Latinos and Asian Americans reported stronger feelings of embarrassment and shame about struggling with a mental illness than their counterparts, which supported the idea that there are differences in attitudes regarding mental health and mental health services stigma among various ethnicities (Jimenez et al., 2013).

Stigma can have several effects on individuals who struggle with mental health issues as it can severely affect personal self-esteem, how one approaches treatment, and the ability to function and adapt to social situations (Depla, de Graff, van Weeghel, & Heeren, 2005). Depla et al. (2005) investigated the impact of experiences with stigma and whether older adults with severe mental illness were stigmatized because of their specific disorder or due to the type of residential facility in which they lived. Of 131 older adults living with a severe mental illness, 57% reported that they experienced stigma due to their mental health. Furthermore, a negative effect of stigma on overall quality of life was noted (Depla et al., 2005).

Language Barriers

According to Barrio et al. (2008), 90% of Latino older adults speak Spanish in the home, and their numbers are growing. Language barriers are an issue for Latino older adults who speak predominantly or only Spanish, as most agencies struggle to provide interpreters and staff members who are able to speak the client's native language (Solway et al., 2010). In a qualitative study conducted in San Diego, California, mental health consumers, caregivers, providers, and advocates participated in semi-structured interviews and focus groups regarding the currently unmet needs of Latino older adults

by mental health services (Barrio et al., 2008). The most significant barriers on an organizational level mentioned by all participants were cultural and language obstacles, particularly difficulties finding translators or professionals who were able to speak Spanish. Additionally, some caregivers and consumers spoke of a lack of resources and general information about mental health services, particularly published in Spanish. Furthermore, professional resources and assessment tools are often unavailable in a language that the client understands (Solway et al., 2010).

Many Latino individuals who do not speak English have poor experiences with medical professionals when they are unable to navigate these communication issues; this thus creates hesitation on their part when thinking about future services (Documet & Sharma, 2004; Hansen & Aranda, 2012). Hansen and Aranda (2012) further explored the concept of language acculturation, which "refers to the degree in which a person uses a native language other than that of mainstream society in social, personal, and professional settings" (p. 2135). According to these authors, older adults who have a lower level of language acculturation typically struggle with identifying resources, which in turn prevents them from accessing appropriate services (Hansen & Aranda, 2012). Kim et al. (2011) explored how limited English proficiency affects the use of mental health resources among Latino and Asian immigrants with a diagnosed psychiatric disorder. They found that having limited English proficiency was a considerable obstacle for those Latino participants who were suffering from mental illness (Kim et al., 2011).

Cultural Competence and Sensitivity

Providing appropriate and effective services to Latino clients involves being able to provide understanding and acceptance of cultural differences (Castaño, Biever,

Gonzalez, & Anderson, 2007). Unfortunately, many of the mental health services available to Latino older adults do not take into consideration cultural perspectives and lack sensitivity regarding these differences, causing more disconnect between these consumers and their mental health providers (Barrio et al., 2008). Cultural values can be a powerful deterrent in seeking mental health services and without a better understanding and integration of cultural competency, many Latino older adults continue to face this barrier in regards to finding support for mental health issues (Barrio et al., 2008; Chavez-Korell et al., 2012; Solway et al., 2010). In the qualitative study by Barrio et al. (2008), the authors identified that many Latino older adults were not open to accessing services that did not take into consideration cultural responsiveness.

Family is a significant aspect of traditional Latino culture and must also be considered when attempting to provide mental health services. Within the study by Barrio et al. (2008), mental health providers and caregivers expressed that many Latino older adults are more willing to cope with mental illness within their own family, many times not accessing available services due to fear of stigma and being categorized as having a mental illness. Furthermore, in the same study family members and current consumers of mental health services identified that many older adults were hesitant to accept help from younger individuals they perceived as lacking knowledge about problems that might occur with aging. Many Latino older adults rely quite heavily on family and close friends and will turn to them for social support when struggling with problems (Rastogi, Massey-Hastings, & Wieling, 2012). Many times, the cultural values and expectations within the traditional Latino community do not match the mental health

services and therapy supports are available to them (Rastogi et al., 2012). However, navigating that gap is essential to providing services to this underserved population.

Home-Based Mental Health Services

There are several barriers and obstacles that make it difficult for older adults and Latino older adults in particular to find effective and accessible mental health services. Addressing this issue is of significant importance as the consequences of neglecting this population can have a heavy impact on life expectancy, quality of life, and recovery from illness, while also increasing the longer-term costs of geriatric care (Karlin & Fuller, 2007; B. G. Knight & Sayegh, 2011; Scogin, Welsh, Hanson, Stump, & Coates, 2005). Many older adults who are struggling with depression tend to have a much higher rate of accessing medical services and higher medical expenses compared to other older adults (Gitlin et al., 2013; Karlin & Fuller, 2007). Karlin and Fuller (2007) reported that the possibility of hospitalization among older adults with mental illness is almost 300%, thus placing a financial strain on supportive services, as well as increased overall medical costs. In order to support those older adults in need of mental health services, there must be an increase in the services available to them, as well as an increase in non-traditional alternatives to current systems of delivery (B. G. Knight & Sayegh, 2011; Kohn et al., 2004).

The organization of the current mental health system in the United States is comprised of several disparate care structures funded by public, private, and voluntary entities (B. G. Knight & Sayegh, 2011). As such, within these systems, mental health services are delivered to older adults in a variety of ways. According to B. G. Knight and Sayegh (2011), mental health services accessed at community centers and state hospitals

have decreased considerably, while services at private, for-profit organizations have increased. Among those services are outpatient, inpatient, and day treatment programs that provide mental health supports to individuals. Despite the availability of these resources, barriers still exist in the provision of services to older adults. As such, there is a push to explore mental health services and interventions that fall outside the current traditional methods (Bruce et al., 2005). One potential alternative to agency based services is providing mental health interventions in a home-based setting (Bruce et al., 2005; Kohn et al., 2004). Home-based mental health services may include a combination of therapeutic supports, referrals, assessment, and case management services for older adults (Bruce et al., 2005).

In a study by Ciechanowski et al. (2004), the effectiveness of an in-home mental health program aimed at assisting older adults with minor depressive symptoms or dysthymia was evaluated. One hundred thirty-eight older adults, aged 60 and older, participated in the study with 51.4% considered to be experiencing minor depression and 48.6% diagnosed with dysthymia. The participants were then randomly assigned to a usual care group or the in-home mental health program, named Program to Encourage Active Rewarding Lives for Seniors (PEARLS). The clients were assessed for depression and quality of life at the initial start of their involvement and then again a year following their integration into the program. The authors reported that PEARLS participants were more likely to have a 50% decrease in symptoms of depression, experience remission from their depression, and have overall improvements in their emotional and functional well-being, as well as quality of life (Ciechanowski et al., 2004).

A similar study by Gitlin et al. (2013) examined the effects of home-based interventions in reducing symptoms of depression and improving quality of life in older adults; however, the specific target population was African American older adults. Participants were at least 55 years old and had depressive symptoms. One hundred eighty-two participants completed 4 months of the program, while 160 of those completed a final total of 8 months of treatment. The in-home intervention included up to 10 hour-long sessions during the first few weeks of the program, with sessions then occurring biweekly for the remaining 4 months. Included in the intervention was an assessment about care needs not currently being met; linkages to social, medical, and personal resources; psycho-education regarding depressive symptoms; coping techniques; and client-created behavioral goals and plans to achieve change and success. At 4 months, those individuals who were receiving services demonstrated a reduction in the severity of their depression, improvement in their knowledge of depression, improvement in their quality of life, and more progress in behavioral changes and improving anxiety compared to those participants not currently involved in the program. After 8 months, participants still involved in the program maintained their progress and benefits (Gitlin et al., 2013).

Advantages of Home-Based Mental Health Services

There are several advantages to using a home-based delivery system for mental health services (Kohn et al., 2004). In terms of accessibility, as services are provided in the home of the client, programs that provide this type of mental health resource address issues of mobility and lack of transportation (Yang et al., 2009). Additionally, home-based services provide interventions for those older adults who may be compromised due

to health reasons and not able to leave their home readily (Kohn et al., 2004). Furthermore, those older adults who struggle with being labeled or stigmatized as having a mental illness can receive services without augmenting those feelings by having to travel to an outpatient program, thus improving the possibility of stronger rapport with providers and a decrease in their resistance to receiving services (Yang et al., 2009). Additionally, engaging clients in their home, as opposed to an office, many times leads to opportunities to learn more about the client, the living environment, daily activity functions, and even social supports (Kohn et al., 2004; Yang et al., 2009).

Challenges of Home-Based Mental Health Services

While there are several advantages to providing mental health services in the home, certain challenges arise as result of using a non-traditional setting (Maxfield & Segal, 2008; Yang et al., 2009). When using a traditional office setting, certain environmental factors are accounted for due to the nature of a professional office (Yang et al., 2009). With home-based services, there is no guarantee regarding the home environment; therefore, clinicians may need to be flexible while also maintaining appropriate guidelines and adequate foresight into potential problems during the visit (Mafield & Segal, 2008; Yang et al., 2009). Additionally, interruptions in office visits are limited and generally the office itself promotes a professional environment, making it easier to maintain professional boundaries and roles (Maxfield & Segal, 2008; Yang et al., 2009). However, interruptions in home settings can be difficult to manage due to the comings and goings of others who live in the home (Maxfield & Segal, 2008).

Maxfield and Segal (2008) presented a case study whereby in-home cognitive behavioral therapy was provided to an older adult female who was dealing with

depressive symptoms. Confidentiality became an unusual challenge during visits as the client verbalized distress and uneasiness about the possibility of being overheard by family members living in the home with her. Additionally, the authors made reference to setting appropriate boundaries and reiterating the importance of establishing clear expectations in order to ensure that clients are aware that visits are to provide a professional service and are not a social call (Maxfield & Segal, 2008).

Conclusion

As the number of older adults in the United States continues to rise, the need for appropriate mental health services to care for this population grows with it. Providing these services is vitally important to improving the well-being of those older adults in need of mental health support. Although it is clear that there are several barriers to accessing services among older adults in general and Latino older adults in particular, innovative and creative programs can help meet these obstacles and enable this population to build connections to community resources. While there are admitted challenges to providing mental health services in the home, the implementation of home-based mental health programs that meet the ethnic, cultural, and mental health needs of older adults provides a unique opportunity to expand on the current method of delivery and reach a larger population of those older adults in need of support.

CHAPTER 3

METHODS

Identification of Potential Funding Source

Several strategies were used to identify potential funding sources for this project. Initially, in order to identify general funding sources and organizations, search engines such as Google Scholar and Google were utilized. The grant writer used keywords such as "grant," "older adults," "funding," "mental health," "Latino," "Latino older adults," "depression," "home-based services," and "home-based treatment" to assist in the search for funding. A variety of privately and publicly funding sources on the local, state, and federal levels were explored for consideration through Grants.gov. Additionally, organizations with websites such as the John A. Harford Foundation (www.jhartfound.org), Archstone Foundation (www.archstone.org), Substance Abuse and Mental Health Services Administration (http://beta.samhsa.gov/), and U.S. Department of Health and Human Services (www.hhs.gov) were examined.

Following the initial search, several potential sources were found to be incompatible with the project due to differences in the target population of interest, budget limits, and other limitations. The grant writer narrowed down the remaining possible funding options by evaluating the restrictions, requirements, and expectations of each potential source on an individual level. Through this process the grant writer was

able to identify a funding source that supported the topic and target population of interest and the goals of the project.

Criteria for Selection of Actual Grant

Several considerations were taken into account when searching for an appropriate funder for this project. The most significant factor was identifying a foundation that shared the project's goal of supporting older adults and improving their mental health. Additionally, important was identifying a funder that would be willing to support this project within Los Angeles County or Southern California. Furthermore, it was necessary to find a funder that did not impose a limit on the amount of funding requested and instead based the amount awarded on the potential complexity and size of the project, while also providing an opportunity for continued funding for additional years. These criteria proved to be difficult to fulfill and many funding sources were dismissed as they were unable to match the needs of the program.

Description of Funding Source and Submission Process

The grant writer chose the Archstone Foundation as the final funding source. The Archstone Foundation is a privately funded foundation that was created in 1985, originally under the name FHP Corporation (Archstone Foundation, 2014). The FHP Corporation was created as a non-profit grant-making organization that dedicated itself to focusing on the health-related issues and the broad spectrum of health care delivery. However during 1995 to 1996, the name FHP Corporation was changed to the Archstone Foundation and their mission began to focus more exclusively on the aging process. By focusing on more concentrated issues related to aging, the foundation's Board of Directors felt that they would be able to effect a more significant change in society

(Archstone Foundation, 2014). Over the span of the past two decades, the Archstone Foundation has awarded more than 80 grants, totaling over $86 million in awarded funds. The Archstone Foundation continues to fulfill its mission of supporting society as it prepares to meet the needs of those who are aging (Archstone Foundation, 2014).

In order to begin the submission process, a letter of intent is required. If the foundation agrees with the goals and priorities listed within the letter, the grant writer will then be allowed to submit a formal proposal. Within the proposal, an executive summary is requested, to include the reason and need for the project, thorough information that supports the issues needing to be addressed, specific background information on the organization, a description of the proposed program (i.e., timeline, goals, objectives), the plan for program evaluation, a description of project staff, the plan for sustainability, and a line-item budget and budget justification for the entire project (Archstone Foundation, 2014). After the proposal is submitted to the foundation, it is reviewed by the Proposal Review Committee, which meets on a quarterly basis. Following their deliberations, this committee then provides recommendations to the Board of Directors, which also meet quarterly. The entire review process can take up to 4 months from the initial submission of the letter of intent to funding.

Needs Assessment and Collection of Data Needed for the Grant

In order to assess the need for home-based mental health services for Latino older adults, the grant writer explored several methods of collecting appropriate data. One approach used was the completion of a thorough literature review. Additionally, the grant writer engaged staff at Beach Cities Health District to confirm the need for this type of program.

Within the scope of the literature review, it was revealed that previous research studies had evaluated the effectiveness of home-based mental health services among older adults with depression and they were found to be helpful in improving depressive symptoms, as well as general quality of life. Additionally, these types of home-based services make it easier for older adults to obtain supportive mental health care even though many are unable to move easily due to mobility issues, health concerns, or lack of transportation.

According to discussions with Beach Cities Health District staff, the Latino older adult population is underserved within the district boundaries of the organization. Several issues were identified as contributing factors, such as lack of social workers who speak Spanish to provide services, lack of materials in Spanish, lack of outreach due to language obstacles, and clients' fear that obtaining services would put a focus on their immigration status. By implementing a program that employs Spanish speaking social workers, several of these obstacles could be greatly reduced, particularly by providing outreach and explaining services in Spanish as well as English. Ultimately, implementing this type of program would allow for this agency to reach a larger population of older adults who suffer from mental health issues and are currently not receiving services due to language and cultural barriers.

CHAPTER 4

GRANT PROPOSAL

Executive Summary

The purpose of this project is to provide a home-based mental health service program for Latino older adults 65 years and older suffering from depression and living in Hermosa Beach, Manhattan Beach, and Redondo Beach. This program will provide biopsychosocial assessments, therapeutic services in the client's home to improve depressive symptoms, and better access and connection to community resources and support. Additionally, this program will offer psycho-educational opportunities for its participants to learn about depression and effective coping skills.

This home-based program is expected to decrease symptoms of depression and improve quality of life among participants who otherwise may be unable to access services due to potential obstacles such as mobility and/or transportation issues, compromised health, fears of stigmatization, and language barriers. When compared to more traditional practices provided in an office setting, home-based services often provide improved opportunities to build greater rapport with clients and a stronger understanding of the social and environmental factors affecting their daily functioning (Kohn et al., 2004; Yang et al., 2009). All components of this program will be available in Spanish and English to ensure that all clients are able to receive services in the language which is most comfortable for them. The goals of this program are to enhance

overall knowledge of depression, increase familiarity with effective coping skills, and decrease depressive symptoms in participants through therapeutic interventions.

Host Agency

The host agency for this proposed project will be Beach Cities Health District (BCHD), located at 514 N. Prospect Avenue, Redondo Beach, CA 90277. In 1955, BCHD was created to manage South Bay Hospital; however, following the closure of the hospital in 1998, the Board of Directors elected to change the focus of the organization to preventive health care and improving wellness across the lifespan (BCHD, 2014). Currently, BCHD has several programs to assist older adults by preventing health-related problems and enhancing their independence and well-being. Many of their programs focus on improving the physical health of older adults by providing fitness classes and in-home exercise programs. Additionally, BCHD provides resources for social support and improved mental health by offering support groups and conversation companions. The care management program at BCHD was specifically created to assist older adults and disabled adults by providing confidential home visits and assessments by social workers to help residents remain in their homes as long as safely possible. They additionally provide linkages to community services and resources.

The mission of BCHD is to promote overall community health through a variety of services, programs, and resources for those who reside in the areas of Hermosa Beach, Redondo Beach, and Manhattan Beach (BCHD, 2014). The proposed program supports the mission of BCHD by providing an opportunity to improve the mental health and quality of life of older adult community members dealing with depression.

Background Literature

The CDC (2014) reported that about 25% of the adult population in the United States suffers from mental illness, with at least half of the population vulnerable to experiencing some sort of mental illness during their lifespan. The impact of mental illness on an individual is often detrimental, significantly affecting the emotional state of a person by causing increased difficulty regulating feelings and emotions, maintaining relationships with others, and functioning appropriately in common day-to-day settings (Bruce et al., 2005; CDC, 2014; Solway et al., 2010). Although mental illness in the United States varies greatly in terms of type of disorder and severity, the National Institute of Mental Health identifies major depressive disorder as one of the more prevalent types of mood disorders, affecting 6.7% of adults (National Institute of Mental Health, 2014).

Depression can manifest itself in several different ways, affecting some individuals intermittently with feelings of deep sadness over a varied amount of time, while others are affected more severely and are given a formal diagnosis of major depressive disorder or persistent depressive disorder (CDC, 2014; National Institute of Mental Health, 2014). Depression in older adults is a substantial issue, as depressive symptoms can severely affect an older adult's functional ability, exacerbate physical problems, and create a decline in functioning at the cognitive level (M. Knight & Houseman, 2008; Maxfield & Segal, 2008). According to Maxfield and Segal (2008), it is estimated that between 15% and 25% of the older adult population experience symptoms of depression. Although depression rates among those 65 years and older are not as high as those in their younger counterparts, the probability of this population dying

as a result of suicide is much higher (Corcoran et al., 2013; Chippendale, 2013). The CDC (2008) reported that men who are 85 years old and older have one of the highest rates of suicide across all gender and age groups.

Providing effective mental health services to those who suffer from mental health issues is often difficult across age groups, as there are many obstacles that affect accessibility (B. G. Knight & Sayegh, 2011). However, older adults experience certain age related challenges that add additional barriers. Many older adults are resistant to accessing mental health services due to a lack of awareness of their availability, a reluctance to acknowledge a need for help, and fear of the stigma of being labeled as having a mental illness (Choi et al., 2013). Additional challenges face older adults attempting to access traditional mental health services such as transportation and mobility issues, as many have given up driving due to physical ailments and do not have consistent access to transportation (Bruce et al., 2005). Cultural sensitivity and language barriers are also issues that many times are not considered when providing services to this population, making them less likely to access or continue with treatment (Solway et al., 2010).

Description of the Project

The main focus of this program is to provide therapeutic support and education to Latino older adults suffering from depression. Participation in this project is strictly voluntary, with participants being referred to this program by BCHD care managers, personal physicians, hospitals, community centers, retirement homes, and senior housing projects. Once referrals are received and contact information verified, the program supervisor will contact the individuals referred, verify their interest in the program, and

set up an appointment to complete the screening process. Those clients who are able to travel to BCHD will meet there for the screening, while those who are unable travel will be met in their homes. Inclusion into this program will be based off the following criteria: (a) 65 years and older, (b) Latino, and (c) documentation of having been formally diagnosed with depression by a physician. Potential participants for this program will be considered ineligible for the following reasons: (a) do not meet the inclusion criteria, (b) report significantly severe mental health symptoms that would be better suited in a more intensive program, and (c) demonstrate significant cognitive impairment based on the Saint Louis University Mental Status Exam (SLUMS; D. H. Brown, Lawson, McDaniel, & Wildman, 2012). Those individuals who do not meet the criteria for this program will be referred to other programs and provided with additional resources. For those participants who are considered eligible and wish to be a part of this program, a consent form will be signed by them or their guardian and an appointment made for the initial visit and assessment.

Following the initial appointment and assessment, either the program supervisor or a social work intern will provide weekly, hour-long therapeutic and psycho-educational sessions to participants over the span of 16 weeks. Modifications to the number of sessions needed per week will be adjusted to meet the needs of the client. Following the initial 16 weeks, the social worker will determine whether the participant is ready for termination or whether an extension of services, in increments of 4 weeks, would be beneficial to the client. Due to the nature of this program, participants may start and end at different points within the year but cannot begin the program if it is past the 8th month of the program's funding duration, as they would be unable to complete 16

weeks of treatment and thus be unable to give valid feedback on the evaluation instrument. Such individuals will be referred to other BCHD services and/or other community resources. The anticipated number of clients served by this program is expected to reach 40, but not exceed 45.

Timeline

Months 01-02: Interviewing and hiring of program staff, purchasing of necessary program equipment, outreach to referring agencies, creating and refining program evaluation tool, and beginning to compile a list of potential participants who meet the inclusion criteria.

Months 03-08: Scheduling and completion of initial visits and assessments for participants, ongoing weekly visits to clients' homes by program supervisor or interns, program evaluation completion for those participants who terminate. During month 8, the last of the participants will begin the program.

Months 09-12: Continuing ongoing weekly visits to clients' homes by program supervisor and interns, beginning to prepare remaining clients for termination as the end of the year draws near, close out all clients by the end of month 11 and refer as needed. Complete all program evaluations.

Month 12: Complete the final analysis of all program evaluations and prepare the final report based on those results.

Goals and Objectives

Goal 1: Reduce symptoms of depression in Latino older adults.

Objective 1: Participants will engage in therapeutic interventions during the 16-week program to improve depressive symptoms and increase emotional well-being.

Outcome 1: Among all participants, at least 80% will demonstrate at least a 3 point improvement from pretest to posttest on the Geriatric Depression Scale.

Goal 2: Participants will show improvement in personal coping skills.

Objective 2: Through the sessions with a social worker, participants will learn new and effective coping skills to assist them in dealing with their symptoms of depression.

Outcome 2: Upon completion of the 16-week program, at least 80% of the participants will show knowledge of at least two new coping skills, as demonstrated by listing those techniques on the posttest.

Goal 3: Participants will demonstrate a greater knowledge of depression.

Objective 3: Through the program, participants will be provided with psycho-educational information about depression and its effects.

Outcome 3: Participants will show at least a 75% increase in knowledge of depression from pretest to posttest, as demonstrated by their answers to true/false questions regarding depression.

Activities

Upon entry into the program, participants will complete a thorough biopsychosocial assessment and pretest with their social worker. This initial session may range from 1 to 3 hours. The assessment will be completed in either English or Spanish, depending on the preference of the participant. All staff in the program will be fully bilingual in English and Spanish. Following the initial session, each participant will have at least one weekly visit with the social worker. These visits will incorporate a mixture of therapeutic interventions and psycho-education activities. As each participant will

have his or her own unique needs, the exact format of each session will be determined as needed by the social worker in conjunction with feedback from the client.

In order to meet the goal of reduced symptoms of depression, cognitive behavioral therapy (CBT) will be used as the main form of therapeutic intervention. While there are several treatment options available to address depression in older adults, CBT is one of the most thoroughly studied and documented as being effective for depression (Scogin et al., 2013). By means of the CBT, participants will begin to understand the relationships among their behaviors, thoughts, and emotions and how these interactions affect them (Cox & D'Oyley, 2011). Additionally, the participants will be provided emotional support and an opportunity to explore their experiences and feelings.

In order to meet the second goal of improving coping skills among the participants, several different techniques will be used. As each client will have his or her own unique needs, coping skills will differ among participants but may include using a mood journal or log to identify emotional states and thoughts which are helpful or detrimental to the individual, relaxation and mindfulness techniques, and the use of exercise to improve mood (Cox & D'Oyley, 2011). The process of cognitive behavioral therapy incorporates several of these coping skills but does allow for modifications based on the personal needs of the client (Cox & D'Oyley, 2011).

In order to meet the third goal of improving knowledge regarding depression, participants will be provided psycho-educational opportunities during their home visits to learn basic information about depression and how it may affect them on physical, psychological, and social levels. This information will give the participants an

opportunity to understand their disorder more fully and hopefully empower them through the treatment process and into the future.

Evaluation Plan

In order to evaluate overall program effectiveness, several different methods of data collection will be used. During the initial visit and prior to termination, program participants will complete a pre- and posttest that includes the Geriatric Depression Scale which will be used to determine whether there was improvement in depressive symptoms over the span of the program (L. M. Brown & Schinka, 2005). Also included in the pre- and posttest will be a small section with true/false questions focusing on general knowledge of depression and how it affects older adults. These data will be used to evaluate whether the program was effective in meeting the goal of improved knowledge of depression. Included in the posttest will be an open-ended question asking participants to list at least two new coping skills they have learned through the program. The posttest will also provide an opportunity for participants to provide feedback regarding the program and suggestions for the future.

The results from this evaluation plan will be reviewed by the program director and will provide guidelines for program improvements and higher levels of effectiveness. Furthermore, client satisfaction and recommendations for program improvement will be taken into consideration for the future. The number of clients served and demographic data will also be documented and evaluated.

Program Budget

See Appendix for proposed program budget.

Budget Narrative

Program Staff

Program Director: This position requires one full-time bilingual (English/Spanish) Licensed Clinical Social Worker (LCSW) who will oversee all aspects of the program. This includes administration, outreach, supervision of other staff, budgeting, and program evaluation. Additionally, this individual will be in charge of hiring the program supervisor and interviewing and selecting social work interns for the year. This position requires at least 2 years of experience working with older adults in a mental health setting. The salary will be $70,000 per year.

Program Supervisor: This position requires a bilingual (Spanish/English) individual with a Masters in Social Work (MSW). This person will be responsible for reviewing referrals and coordinating appointments for initial visits and assessments. Additionally, he or she will be responsible for implementing the program and providing hands-on training for the interns, when appropriate. The program supervisor will also be responsible for collecting the data from the program evaluations and providing a quarterly analysis review to the program director. The salary will be $45,000 per year.

Social Work Intern: This position requires a bilingual (Spanish/English) individual currently enrolled in an accredited MSW program. This person will be responsible for traveling to and from clients' homes. When available, the intern will assist the program supervisor with various tasks. This position is considered part-time status and has an annual stipend of $2,000. There will be two available positions.

Operations and Expenses

Program Supplies: Approximately $70 per month will be spent on overall program supplies for an annual total of $840. This will cover the costs of paper, folders, charts, pens, and pencils.

Printing: Approximately $350 will be spent per month on printing educational handouts, materials, and information, totaling $4,200 per year.

Equipment: Equipment needed for documentation, accessing resources, and meeting general program needs will be purchased at a total cost $ 3,900 per year. This equipment includes three business computers at a cost of $700 each and three cell phones at $50 per month.

Telephone and Fax: Approximately $150 per month for a total cost $1,800 per year will be used for program phone and fax lines.

Travel: Approximately $500 per month for a total of $6,000 per year will be used to provide mileage reimbursement for the program supervisor and interns to travel to and from the office and clients' homes.

In-Kind Resources

BCHD will provide the office space, utilities, and access to the agency's main server for the program. Rent for the office space would be equivalent to $1,750 month, with utilities costing $250 per month and access to the agency's main server equaling an additional $100 per month. The in-kind contributions will total $25,200 per year.

CHAPTER 5

DISCUSSION

The number of older adults in the United States continues to grow significantly as more and more people in the baby boomer generation continue to age (B. G. Knight & Sayegh, 2011). Among the various needs associated with this population, addressing the mental health concerns of older adults will become increasingly important as they navigate transitions throughout the aging process (Coyle & Dugan, 2012). Only half of the 20% of older adults suffering from a mental health issues are receiving some sort of mental health treatment (Bruce et al., 2005; Solway et al., 2010). The underutilization of mental health services among older adults can be attributed to a variety of obstacles, from inconsistent transportation and poor mobility to being unaware of available services (Bruce et al., 2005; Choi et al., 2013).

Language barriers, stigma, and lack of awareness of cultural factors are some of the obstacles that are also present for Latino older adults in need of mental health support (Jimenez et al., 2013; Solway et al., 2010). With the number of Latino older adults expected to increase by 224% by the year 2050, addressing the underutilization of mental health resources by Latinos is imperative. The establishment of programs that offer bilingual social workers and language-appropriate materials will help meet the needs of this underserved group, while also providing an opportunity to gain insight into more effective ways to support them.

Lessons Learned

One of the most educational parts of this process was the completion of the literature review. By exploring the information found in scholarly articles, this writer was able to gain a better understanding of older adult and Latino older adult populations, mental health concerns among these groups, barriers to treatment, and programs shown to address those barriers.

One of the more challenging aspects of this process was the writing of the grant proposal. The experience improved the writer's ability to find an appropriate funding source, complete a needs assessment, and to plan for an actual program. An area that the writer found difficult to integrate into the program proposal was how to meet the individual therapy needs of participants while also establishing a feasible duration of treatment that would allow an appropriate time for the evaluation of program effectiveness. The creation of a program budget was also an informative experience, shedding light on the various expenses involved in running an effective program.

Implications for Social Work Practice

Those in the field of social work are in a unique position to create, evaluate, and refine programs to address the mental health needs of the older adult population. Innovative and distinctive programs will be needed to overcome barriers and obstacles to reach older adults as whole, but especially those individuals who are members of cultural and/or ethnic minority groups, most of whom are significantly underrepresented in treatment programs. Particularly important are providing culturally competent services and meeting the language needs of minority groups. Additionally, educational opportunities should be created to provide information to family members, caregivers,

medical personnel, and older adults themselves regarding the availability of resources and services. Through such efforts, the field of social work can help bridge the gap between available mental health resources and those among the older adult population who struggle to access them.

APPENDIX

PROPOSED PROGRAM BUDGET

Proposed Program Budget

Salaries and Benefits

Program Director/LCSW/FTE/100%	$70,000
Benefits and Taxes@31%	$21,700
Program Supervisor/MSW/FTE/100%	$45,000
Benefits and Taxes@31%	$13,950
Social Work Intern (2,000 each), Bilingual (Stipend),	$4,000
TOTAL SALARIES AND BENEFITS	$154,650

Direct Program Costs

Program Supplies	$840
Printing	$4,200
Equipment	$3,900
Telephone and Fax	$1,800
Travel	$6,000
TOTAL DIRECT PROGRAM COSTS	$16,740

In-Kind Resources

Rent	$21,000
Utilities	$3,000
Main Server Access	$1,200
TOTAL IN-KIND RESOURCES	$25,200
TOTAL PROJECT COSTS	$171,390
REQUESTED AMOUNT	$146,190

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