ABSTRACT

SERVING OLDER ADULTS WITH MENTAL ILLNESS: A REVIEW OF APPROACHES TO CASE MANAGEMENT

By Rachel A. Tomsic

The purpose of this study is to explore how case management services are being provided to older adults with chronic and persistent mental illness, the challenges they face in providing those services, and whether or not there is an optimal approach to providing these services effectively and appropriately. Focus groups with case managers and interviews with program managers/team supervisors were conducted with five Ohio community-based mental health agencies. These mental health professionals were able to openly discuss the challenges they face as they struggle to provide effective, holistic, and appropriate services to older adults with chronic mental illness. The key findings to emerge from this study were the array of system challenges case managers encounter when providing mental health services.
SERVING OLDER ADULTS WITH MENTAL ILLNESS:
A REVIEW OF APPROACHES TO CASE MANAGEMENT

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by
Rachel Ann Tomsic
Miami University
Oxford, Ohio
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Advisor______________________________________
Robert Applebaum, Ph.D.

Reader______________________________________
Kathryn McGrew, Ph.D.

Reader______________________________________
William Ciferri, MGS, MBA
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CHAPTER I

Introduction

This study explores the ways in which community-based mental health agencies are providing case management services to older adults with life long, persistent and chronic mental illness. Five community-based mental health agencies were selected throughout Ohio; two of which provide specialized geriatric case management services and the other three providing integrated case management services (traditional services) to all adults over the age of 18. Through the use of focus groups with case managers and individual interviews with Program Managers/Team Supervisors, these mental health professionals were able to openly discuss the challenges they face as they struggle to provide effective, holistic, and appropriate services to older adults with chronic mental illness.

History of Older Adults and Mental Illness

The number of older adults with major psychiatric illness is predicted to more than double by 2030 (Jeste, 1999). Psychiatric disability or severe and persistent mental illness as defined by the Center for Mental Health Services is “any psychiatric disorder present during the past year that seriously interfered with one or more aspects of a person’s daily life” (www.mentalhealth.samhsa.gov/cmhs/mentalhealthstatistics.com).

In 1981 the term chronically mentally ill was used and included those with a diagnosis for a major mental illness, severe disability, and duration of illness for at least one year. A more recent definition refers to persons with severe mental illness, which includes all diagnoses, substantial disability, and no required duration (Kuntz, 1995).

An estimated 22.1 percent of Americans ages 18 and older—about 1 in 5 adults—suffer from a diagnosable mental disorder in a given year. When applied to the 1998 U.S. Census residential population estimate, this figure translates to 44.3 million people. In addition, 4 of the 10 leading causes of disability in the U.S. and other developed countries are mental disorders—major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder (www.nimh.nih.gov/healthinformation/statisticsmenu).

Historically, people with any type of mental disability regardless of the severity were placed in institutions or asylums for the insane; often times up until their death. Efforts in the
past twenty years toward finding more effective alternatives to institutionalization for persons with severe mental illness (SMI) have led to the development of psychiatric rehabilitation services, also known as psychosocial rehabilitation; a term that encompasses several types of community-based mental health treatments. Not all persons with a mental illness require psychosocial rehabilitation services; the most frequent diagnoses of persons needing this type of service include schizophrenia, bipolar disorders, depression, and severe personality disorders (Kuntz, pg 7). Currently, all people with SMI can receive services from a variety of community based services which include outpatient psychotherapy, partial hospitalization/day treatment, crisis services, case management, and home-based and “wraparound” services” (AoA 2001).

According to the Ohio Department of Mental Health (ODMH) there were 28,398 active clients over the age of 65 within Ohio’s mental health system in 2004. Today we are seeing clients with living longer into what we call later life. A recent study of a local community mental health agency in Southwestern Ohio, found a noticeable increase in the number of aging SMI clients who are now 55 years of age and older. In 1990, 10 percent of all clients served by this agency were 55 and older; in 2004, 17 percent of this agency’s clients are over age 55. This trend is due in part to improved access to public health and general health care; improvements in nutritional education and medication; and finally, improved symptom management and treatment of mental illness by mental health professionals (Tomsic, 2004).

**Older Adults and the Mental Health System**

The context of mental health services for older adults has changed substantially during the last two decades. As part of a larger public policy of deinstitutionalization there were increases in both institutional and outpatient services. In the institutional sector, inpatient services shifted from state mental hospitals to private psychiatric hospitals and psychiatric units in general hospitals. Older adults represent 11 percent of the population receiving care in specialty institutions and general hospitals (Rosenstien et al 1990 cited in Smyers et al., 1999). but nursing homes have increasingly taken on the care of older mentally ill adults. Consequently, older adults make up 90% of all mentally ill cases in nursing homes (Smyers et al., 1999).
When considering the older mentally ill client it is important to note that the older client’s ability to successfully live independently, take medication as prescribed, and maintain appropriate self-care may be related to the form of mental health treatments available to those clients at the time of their initial psychiatric diagnosis. For example, many of the oldest individuals with early onset schizophrenia developed their disorder before the introduction of antipsychotic medication, at a time when long-term institutionalization was the rule for psychotic disorders. In general, these groups of patients lack independent living skills, have poor social skills, and depend on a structured supervised setting to meet their needs (Smyer & Qualls 1999, pg 187). More recently, a different group of early onset schizophrenia (EOS) older patients has emerged. These individuals are the “young old” (in the 60’s) and are among the first wave of severely mentally ill patients who became ill when states were closing their long-term wards and shifting treatment into the community. This historical cohort of younger patients with schizophrenia includes individuals who have developed independent living skills and are more likely to continue to live independently in the community in later life (Smyer et al, pg 194).

**Older Adults with Mental Illness**

Some characteristics of the “typical” older adult with chronic mental illness who has been in the mental health system for most of his/her life are: an early onset of mental illness; early involvement with the mental health system, minimal family support and/or other support systems, low education, typically receiving Medicaid and/or Medicare, minimal work history, and, receiving benefits such as Supplemental Security Income (SSI), or in some cases Social Security Disability Income (SSDI).

It is important to consider the fact that older adults who have had a chronic history of severe and persistent mental illness are now aging within the mental health system. This makes their involvement, experience, and needs in the mental health system much different than older adults who enter the mental health system later in life.

When considering how services are provided to older clients with SMI, it is important to acknowledge three main risk factors that make services to older SMI clients unique, challenging,
and necessary. These are: (1) Cohort issues, (2) Co morbidity issues, and (3) Psychosocial issues.

Cohort Issues: Cohort issues pose generational barriers that cross and overlap between patient, provider, and system entities. The 1999 U.S. Surgeon Generals report states:

“The largest unmet need for treatment of mental disorders reflects (1) patient barriers such as preference for primary care, tendency to emphasize somatic problems, reluctance to disclose psychological symptoms, (2) provider barriers such as a lack of awareness of the manifestations of mental disorders, complexity of treatment, and reluctance to inform patients of a diagnosis, and finally (3) mental health delivery system barriers such as time pressures and reimbursement policies” (p. 341).

Additionally, there are other possible reasons why mental health problems associated with older adults do not get much attention. One major factor has to do with ageism brought on the part of mental health and medical professionals as well as older adults themselves. Too often, the signs and symptoms that accompany mental illness in older adults are seen as “symptoms of old age.” Older adults and oftentimes family members “believe that ‘senility’ is normal and therefore may delay seeking care for relatives with dementing illnesses” (Surgeon General’s Report, pg. 341). It is also important to note that older adults and their families may view depression and hopelessness as a natural condition of old age, especially after the death of a spouse or loved one (Surgeon General’s Report, 1999).

Co morbidity Issues: Co-existing or co-morbid issues pose a more immediate and costly risk to older adults with SMI and the mental health system because of poor general health and the high number of medications taken by SMI clients; especially as physical health changes and/or declines. The clinical challenges such conditions present may be exacerbated, moreover, by the manner in which they both affect and are affected by general medical conditions or by changes in cognitive capabilities (Surgeon General’s report, 1999). Older people are often under-treated for their mental disorders in primary care settings. When they do receive appropriate treatment, older people are more likely than other people to have co-morbid disorders and social problems that reduce treatment effectiveness (Surgeon General’s report, 1999). It is also understandable that detecting and accurately diagnosing mental disorders in
older adults is complicated by co-existing symptoms from other medical disorders. The symptoms of mental and physical illnesses may mimic or mask each other; making diagnosis more complicated and often times inaccurate (Ohio Action Report, 2001). Another factor to consider is that an untreated mental disorder can turn a minor medical problem into a life-threatening and costly condition. Problems with forgetting to take medication (e.g., with dementia), developing delusions about medication (e.g., with schizophrenia), or lowering motivation to refill prescriptions (e.g., with depression) can increase the likelihood of having more severe illnesses that demand more intensive and expensive institutional care (Surgeon General’s Report, 1999). Additionally, the older person with SMI is subject to the double jeopardy of an increased risk of medical illness associated with advancing age in conjunction with the increased risks of medical illness associated with having a SMI. According to Bartels (2004) “The cumulative long-term effect of poor health behaviors and long-term exposure to psychiatric medications with substantial metabolic and neurological side effects places the older person with SMI at a greater risk of respiratory, cardiovascular, and endocrine disorders” (pp. s251).

**Psychosocial Issues:** The final risk factor affecting older SMI adults are psychosocial stressors. Many older adults experience loss with aging—loss of social status and self-esteem, loss of physical and cognitive capacities, and death of friends and loved ones (Surgeon Generals report, 1999). Such losses can lead to depression, isolation and disconnection from already established services, which for older SMI clients could exacerbate, or complicate ones mental status and stability. It is also important to note that depression is a foremost risk factor for suicide in older adults. Older people have the highest rates of suicide in the U.S. population: suicide rates increase with age, with older white men having a rate of suicide up to six times that of the general population (Surgeon General’s report, 1999).

**Current Mental Health Delivery System**

Community-based mental health centers often provide a combination of services with case management being the primary service to SMI clients. Case management services may include one or more of the following activities: assessment; assistance in achieving personal independence in managing basic needs as identified by the individual; facilitation of development of daily living skills if requested by the individual; coordination of the
Individualized Service Plan (ISP); symptom monitoring; coordination and/or assistance in crisis management and stabilization as needed; advocacy and outreach; education and training specific to the individual’s assessed needs, abilities, and readiness to learn; mental health interventions that address symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking or maintaining education and employment; and activities that increase the individual’s functional capacity to positively impact his/her own environment.

Traditionally, case managers often have a case load comprised of all SMI adults regardless of age. Some shifts were made in Ohio to break down case loads based on a client’s severity of mental illness and the amount of service needed to treat that client. Generally, clients 55 and older were mixed in among other clients on a particular case load. In recent years mental health agencies both nationally and in Ohio have begun to examine alternative case management models. For example, some facilities now provide specialized geriatric case management services for older clients while other are providing a “cluster-based” service that divides older clients with SMI into a sub-group that includes any adult with chronic physical health conditions and psychiatric disabilities (www.ohiocouncil-bhp.org). Others continue to provide traditional case management services with no distinction in service to older clients with mental illness. While many Ohio community-based mental health centers would agree that their older clients have different needs than their younger clients, and the number of older clients with mental illness needing continued mental health services will and is increasing, the question remains what is the best way to serve these clients?

Unfortunately there is not a lot of documented literature on the treatment of chronically mentally ill older adults from which to draw best practice models for programming. There is however increasing focus on co-morbidity factors affecting older adults with SMI, which is quickly gaining the attention of many community-based mental health providers. There has been a recent trend to focus on the diagnosis, assessment, and treatment of late-life mental disorders; however, this focus presents a completely different set of treatment characteristics than the treatment characteristics for older chronically ill adults who have been in the mental health system for most of their life. There is a great deal of program potential and best practice opportunities that can emerge from exploring this topic further.
Research Questions

Due to the increasing number of older mentally ill clients receiving and needing mental health services, and, increasing questions about how best to serve these clients, this study will focus on community mental health agencies within Ohio that already provide case management and psychiatric services to adult and older SMI clients. This research is based on the assumption that the majority of clients who are receiving mental health services such as case management and psychiatric follow-up have been receiving community-based mental health services for most of their adult life. This project does not focus on services provided to older adults who have received a later onset mental health diagnosis and are only receiving psychotherapy or psychiatric services to help manage symptoms.

This study focuses on three main research questions.

1. What are the existing models of case management services to older SMI clients within Ohio community mental health organizations (i.e., mixed case loads, specialized teams, and “clustered” services)?

2. What are the challenges case managers encounter while providing these types of services?

3. Is there an optimal approach to providing case management services to older adults with mental illness?

By exploring current models of case management services to older adults with life-long severe and persistent mental illness alternative approaches and suggestions for future practice and research will be identified.
CHAPTER II

Methodology

This chapter describes and provides a rationale for the method used to conduct this study. Since this study seeks to explore how community mental health agencies in Ohio are providing case management services to older mentally ill adults, a qualitative approach was necessary. Qualitative methods are most appropriate in exploring the meaning that people attach to an issue or experience or the sense they make of particular issues or experiences. This method is intended to depict life as participants experience it, rather than in predetermined categories with numerical interpretations (Schutte, 2001). The outcome of (qualitative) studies is not the generalization of results, but a deeper understanding of experience from the perspectives of the participants selected for study (Maykut & Morehouse, 1994, p44). In this study, the use of qualitative methods permitted the opportunity to consider the individual perspectives of case managers and team supervisors, explore the complexities of providing mental health services to severely mentally ill older adults in Ohio, and present experienced-based opinions about how best to serve older mentally ill adults within the mental health system.

Research Design

This study utilizes an interview-based design to explore how community-based mental health agencies are providing case management services to older adults with mental illness. The five community-based mental health agencies used for this project were selected from an Ohio data base (The Ohio Council of Behavioral Healthcare Providers, www.ohiocouncil-bhp.org) which lists all community mental health agencies in Ohio. After selecting agencies from major cities in Ohio, a phone screen interview was conducted (see Appendix C) with a supervisor from each agency to confirm that case management was the primary service provided to clients, what model of case management services used (traditional or specialized), and approximate number of clients over the age of 55. A letter (See Appendix D) was sent to each agency to request an agency visit which included and individual interview with a Program Manager/Team Supervisor and a focus group with the case managers of that team.
Since the main focus of this study is to explore different approaches to providing case management to older mentally ill adults, it is imperative to utilize the participant-as-collaborator approach (Maykurt et al, p. 70). This was accomplished through the use of focus groups and individual interviews. The advantage of focus groups is to bring several different perspectives into contact through a process that is open and emergent (Maykurt et al, p.103). For each focus group an interview guide was utilized (see appendix A) with one case management team from each of the five mental health agencies. Additionally, individual interviews took place utilizing an interview schedule (see appendix B) with a Program Manager or Supervisor from each of the case management teams. All focus groups and individual interviews took place at each selected mental health facility.

**Participants**

Participants in this study were case managers, other essential team members such as case aides, and program managers or team supervisors from five community-based mental health agencies in Ohio. The program managers or team supervisors served as the gatekeeper when scheduling each focus group. The program manager or team supervisor was responsible for contacting the case managers and other essential team members regarding the purpose of this study, and finally scheduling the focus group. According to Maykut &Morehouse (1994), the goal of qualitative study is not generalizeability, rather, “to select persons or settings that we think represent the range of experience on the phenomenon in which we are interested” (pg. 57). For this reason, purposive sampling was utilized to allowed to carefully select participants (agency case managers and Program Managers/Team Supervisors) that represented the range of experiences on the topic of interest (Maykurt et al, p. 57); how best to serve older adults with chronic and persistent mental illness. By selecting agencies throughout Ohio, this allowed for variety in the ways in which case management services were provided and the types of resources available to each agency within their city.

Upon approval of the project by the Miami University Committee for the Use of Human Subject in Research, numerous mental health agencies in Ohio were contacted. Letters were sent to each agency contacted requesting an agency visit.

The purposive sampling used for this study led to five community-based mental health agencies that met participation requirements and agreed to participate in the study. These
agencies were located in all regions of Ohio. These five agencies are all not-for-profit and receive similar funding through the Ohio Department of Mental Health, Medicaid, Medicare, and other private insurances. They also varied slightly by size (total client census and number of employed staff), model of case management service, and organizational structure. Each case management team consisted of at least 6 case managers, with some teams having a combination of case managers, case aids, nurses and peer support.

Data Collection

All participants were aware of the purpose of this project and signed consent forms (See appendix E) prior to the focus group and individual interviews. Focus group and individual interviews were audio-recorded and transcribed. This allowed for accurate analysis of the text of these interviews. Participants were asked to share their opinions about and experiences in providing case management services to older mentally ill clients. The semi-structured focus groups and individual interviews were conducted with an interview guide (see Appendix A and B) designed to allow participants to share as much information as was comfortable for them. Each focus group took place at the mental health agencies, lasting between 50-60 minutes. Individual interviews with team supervisors also took place at mental health agencies and lasted between 60-90 minutes.

Analysis

Text of the focus groups and individual interviews served as the data for analysis. Data were transcribed and line by line analysis took place identifying patterns, concepts, and emerging themes regarding approaches to case management, system barriers, and other factors affecting case management services (resources, funding, and collaborations).

After the initial analysis of data was completed, data charts were developed to provide a comprehensive list of key concepts that were identified from each agency. These key concepts were then categorized into system challenges and agency descriptions. Follow-up questions were asked via email of program managers/team supervisors for clarification on certain statements or inaudible comments from the taped focus groups and interviews.
CHAPTER III

Findings

This chapter presents a summary of the themes and issues that emerged from the focus groups conducted with the case managers and interviews conducted with Program Managers/Team Supervisors from five community mental health agencies in Ohio. Interview and focus group data has been analyzed to understand how case managers are providing services to older adults with chronic and persistent mental illness in Ohio. This chapter provides (1) a description of each agency interviewed, (2) a summary of the system challenges, and (3) approaches to case management services.

Agency Descriptions

This study examined five community-based mental health agencies within Ohio. All agencies were similar in size, ranging from 2600 clients served to 3200 clients served. Two agencies provide specialized geriatric case management services. One team provides a “cluster-type” case management service to adults with mental illness that divides older SMI clients into a sub-group which includes any SMI adult with chronic physical health conditions and psychiatric disabilities (www.ohiocouncil-bhp.org). The remaining two agencies provide integrated (traditional) case management services to adults over the age of 18. The major funding sources for these agencies are Medicaid, Medicare, and Mental Health board levy money (see Table 1). It is important to note that while all agencies are receiving similar funding, the structure of the teams are not similar: The structure of the two geriatric case management teams consists of additional support that includes case aides, and peer support, whereas, the traditional teams do not have these additional supports. All data indicating agency size and number of clients over the age of 55 were taken from the Ohio Department of Mental Health’s MACSIS Data Mart web page for the year 2004. This information is available at (www.dwcubes.mh.state.oh.us.)
Table 1: Description of Mental Health Agencies Participating in Study

<table>
<thead>
<tr>
<th>Agency Size</th>
<th>Clients over 55</th>
<th>Average Caseload Size per CM</th>
<th>Types of CM Models</th>
<th>Funding Sources</th>
<th>Basic Team Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akron, OH</td>
<td>2775</td>
<td>667</td>
<td>Traditional and Specialized Geriatric Teams</td>
<td>Medicaid, Medicare, Mental Health Board Money</td>
<td>Program Manager, Team Supervisors, Case Managers, Case Aides, Nurses, Peer Support, Geriatric Psychiatrist, Agency Psychologist</td>
</tr>
<tr>
<td>Cleveland, OH</td>
<td>2724</td>
<td>475</td>
<td>Traditional</td>
<td>Medicaid, Medicare, Mental Health Board Money</td>
<td>Team Leader, Case Managers, Agency Psychiatrist</td>
</tr>
<tr>
<td>Cincinnati, OH</td>
<td>2594</td>
<td>400</td>
<td>Traditional</td>
<td>Medicaid, Medicare, Mental Health Board Money</td>
<td>Team Leader, Case Managers, Agency Psychiatrist, Agency Nurse</td>
</tr>
<tr>
<td>Columbus, OH</td>
<td>3235</td>
<td>505</td>
<td>Traditional and Specialized Geriatric Teams</td>
<td>Medicaid, Medicare, Mental Health Board Money, Additional Grant Monies</td>
<td>Program Manager, Case Managers, Counselors, Intake Specialist, Peer Support, Agency Psychiatrist, Agency Nurses</td>
</tr>
<tr>
<td>Dayton, OH</td>
<td>2784</td>
<td>243</td>
<td>Traditional and medical CM teams</td>
<td>Medicaid, Medicare, Mental Health Board Money</td>
<td>Program Manager, Team Leader, Case Managers, Case Workers, Agency Psychiatrists, Agency Nurses, Agency Therapists</td>
</tr>
</tbody>
</table>
The primary services provided by all of these agencies are: case management, employment/vocational training, medication monitoring, nursing, psychiatric assessment and evaluation, and residential treatment services. In addition to primary services, each agency may provide additional services to other age groups such as children, youth, and families; they may also target specific populations and/or treatment issues such as homelessness, alcohol and drug addiction. For the purposes of this study, the focus was on each agency’s case management services and the type of case management model they utilized to serve older adults with severe and persistent mental illness.

Case Management and Mental Health

As stated previously, there were three basic case management models identified for this study: specialized geriatric team model, the traditional (integrated) team model, and the “cluster-based” team model. Regardless of the type of model utilized by each community-based mental health agency, the case manager’s primary role includes one or more of the following activities: psychiatric and medical assessment; assistance in achieving personal independence in managing basic needs as identified by the individual; facilitation of development of daily living skills if requested by the individual; coordination of the Individualized Service Plan (ISP); symptom monitoring; coordination and/or assistance in crisis management and stabilization as needed; coordination and/or assistance in getting to and from psychiatric and/or medical appointments; advocacy and outreach; education and training specific to the individual’s assessed needs; mental health interventions that address symptoms, behaviors, and thought processes that assist an individual in remaining independent in the community.

In addition to the direct service responsibilities of case managers, additional responsibilities include: managing and completing all required paperwork, attending agency sponsored trainings, attending required team and/or agency meetings, and meeting with agency Psychiatrists and/or nurses.

During focus group discussions with case managers, they expressed high levels of stress and frustration as they talked about the challenges they face when providing services to older adult with mental illness. This is especially true when you consider the average case load size for all of these teams to be between 35 and 40 clients. The biggest concerns expressed had
to do with time management and productivity requirements; case managers generally feel overwhelmed with all they have to do especially when some services are considered non-billable and don’t count towards their productivity. This becomes even more complicated when you consider some of the barriers that inhibit case managers from providing effective and appropriate services. These barriers, which are termed system challenges and will be discussed further in the next section, have to do with billing policies as directed by the Mental Health Board, Medicaid, and Medicare; agency policies such in paperwork submission requirements, case load sizes, team size and support positions (such as case aides) and general community barriers such as a lack of appropriate older adult programs or age-related resources.

System Challenges

One of the major concepts that emerged out of the five focus groups conducted with mental health case managers and program managers/team supervisors for this study dealt with system challenges. It is the reality of these challenges that makes providing appropriate and effective case management services to older SMI adults difficult and often times overwhelming.

There were five consistent system challenges that emerged from the research. They are listed in order of magnitude based on focus groups and interview responses. These challenges are: (1) Medical Care, (2) Transportation, (3) Housing, (4) Community Resources, and (5) Social Supports. Further analysis of these themes revealed a distinction between issues that were a priority (transportation and housing) based on the clients basic needs and level of case manager involvement, and issues that were recognized as important (declining physical health, community resources, and isolation) but difficult to address due to either a perceived lack of time available for case managers or lack of knowledge regarding the issue. It is important to note that while all teams expressed concerns regarding these five issues, there were other issues expressed in addition to these that are specific to each agency. These issues will be discussed in addition to the five system challenges and are classified as “other”.

Medical Care: This challenge generated a great deal of conversation by all focus group conducted with case managers and Program Managers/Team Supervisors. It also became apparent that this issue is really two-fold: declining physical health of clients and challenges in collaborating with medical professionals. It also appears to be one of those challenges that is recognized as important in the holistic treatment of older adults with mental illness, but difficult to address. Difficulties include the increasing number of older clients with declining physical
health, case manager time constraints, lack of training and understanding about medical issues, resistance to collaboration by most medical doctors, and a shortage of qualified geriatricians. One case manager states:

“I have several older clients and primarily the thing I struggle with them over (vs. other younger clients) are health issues and getting them services for their health issues…it’s not totally mental health because they are still dealing with the same mental health issues that they’ve always had but physical health issues are beginning to impact them greatly”

One contributing factor that seems to further complicate this issue is that many clients don’t have a regular primary care physician and therefore don’t receive routine medical care. This becomes even more complex when a client’s medical needs increase, resulting in multiple doctors making treatment planning and medication coordination problematic for case managers and clients. One case manager expressed:

“When you have too many doctors coordinating (care) you’re then relying on elderly psychiatrically unstable clients to take care of their medical issues.”

Another complicating factor, according to case managers, is (1) the general lack of awareness on the part of medical doctors regarding mental health needs/issues and (2) the stigma that is attached to clients because of their mental illness and their age. Clients generally don’t know how to advocate for themselves and are left trying to manage multiple doctors by themselves. This is clearly expressed by a case manager who states:

“There’s a double stigma; they think that because they’re older and mentally ill, they (client) don’t know what they’re talking about.”

Another case manager adds:

“Unfortunately there’s a stigma in the medical profession—once we identify ourselves as case managers from (Agency), the attitude changes all together, even if you’re talking about the medical issues the client is there for.

Case managers also report that their clients often are not taken seriously by medical doctors because of the mental health stigma. It also becomes difficult to assess if reported and/or observed symptoms are a result of their mental illness or a medical problem, especially with a physician who is not well versed in mental health issues. There are those doctors however that
try to “play psychiatrist” as one case manager put it, and make changes to the clients psychiatric medication regiment without consulting the client’s psychiatrist. This is when, as one case manager strongly stressed,

“We have to be assertive and tell the Doc that we are not here for Psychiatry, we are here for medical treatment.”

Another case manager adds:

“That is a major issue (collaboration with medical doctors), because in my experience I go to appointments, which is another issue, we really have to be very creative in how we justify time spent with a client at the doctor’s office, which is very necessary because a lot of clients tend to forget or minimize and are intimidated by medical doctors…one of the major challenges is finding a competent medical doctor.”

Advocacy plays a huge role when working with medical doctors on behalf of the client. Some case managers report that medical doctors don’t seem receptive to their input as the client’s case manager, nor do they utilize them as a valued resource in treatment planning. Conversely, some case managers report that medical doctors become more attentive to the clients needs once the case manager gets involved.

For those specialized geriatric case management teams who report a stronger rapport with medical doctors and geriatricians, they admit that they still run into problems, such as medical doctors trying to “play psychiatrist” with their clients. However, there appears to be a very strong philosophy in the treatment approach with their clients that is echoed by the medical doctors, especially Geriatricians, who work with these specialized teams. As one program manager matter-of-factly states:

“There’s no way you can do psych stuff without looking at the medical…I mean you’re not just talking about a mind, you know, we work very closely with the medical doctors--can’t do one without the other.”

**Transportation:** There are several reasons that transportation was expressed as a system challenge by case managers. A primary reason for this challenge is the increasing number of medical appointments that older clients have to which case managers must transport. This is further complicated by billing practices and case manager productivity requirements. Medicaid,
the primary funding source for these agencies, does not reimburse for the transportation of clients to and from appointments, which can add up to a considerable amount of time. Because transportation is not billable, this affects each case manager’s documented productivity. Productivity is a targeted amount of billable time that each case manager must spend with their clients. While this is an issue for all case managers, it becomes an even bigger issue for case managers working with older adults. This is mostly due to increasing medical problems resulting in clients needing to see multiple medical doctors for multiple medical appointments. Some of the community mental health agencies interviewed for this study have incorporated the use of case aides or case workers into their team structure to help with this issue. They claim that this helps to free up case manager time for more clinical issues and alleviates the issue of non-billable time for case managers.

All case managers interviewed in this study expressed that it is very difficult to manage the numerous transportation needs of their older clients especially if the client does not have any family or additional support to help with transportation needs. This is clearly expressed by one case manager when discussing transportation issues:

“And yet we have older clients who have few if any support systems in the community and most elderly adults don’t have family or friends who can take care of them—our clients are very isolated, they don’t have that (family support).”

Another common frustration expressed is that there simply is not enough publicly funded transportation resources that can assist clients in getting to and from their medical appointments. One case manager expressed,

“We need transportation services—even at the volunteer places there are volunteers who can take people places, but we don’t have access to them.”

**Housing:** Housing is one of those issues that is a common challenge for case managers no matter the age of the client. It was clearly expressed by the case managers interviewed for this study that housing is difficult to obtain for SMI clients of all ages. A program manager from one agency refers to this challenge bluntly by stating “it (housing) stinks.” It becomes an even more complicated issue with older adults because of the decline in medical and physical status. Often times, older clients are living in apartment buildings that have no elevators with multiple
steps and cramped living quarters. One case manager states when talking about the changing medical needs of her clients and current living arrangements:

“They (older clients) tend to get housing when they are younger which is often times not conducive to live in when they are older…their housing is no longer conducive to their health needs.”

Because most housing provided to adults with mental illness tends to be subsidized housing, securing safe and appropriate housing can most times be a lengthy process involving waiting lists and strict eligibility requirements. Therefore, if a client’s health needs change, especially as they age, to the point where their living environment is no longer conducive to their health needs, it becomes difficult for the case manager to help them move to another apartment either within the same building or in a different building. It then becomes an issue of safety, leaving the case manager few housing options for their clients and making nursing home placement one of the few safe alternatives.

Another issue expressed by case managers is that there simply are not enough assisted living facilities available to older clients. One case manager stated:

“(Lack of housing) is major, we need assisted living housing so so badly. We have people who could live in the community if they had some help.”

Another case manager commented that the assisted living facilities or group homes available to older clients are not equipped to manage the increasing medical needs of their clients. In these circumstances placement into a nursing home becomes the only safe alternative.

**Community Resources:** Connecting clients with additional community resources is essential to effective services provided to adults with mental illness. This becomes even more essential when working with older adults with mental illness due to changes in physical health, changes in independent living skills, need for safer, more appropriate housing, and finally isolation due to loss of family and friends. Overall, this study revealed that there appears to be little awareness of, availability to, and collaboration with age-related community resources for most of the case management teams interviewed for this study. With the exception of one case management team, case managers do not seem to have special collaborative relationships with aging resources. Often case managers attempt to contact area resources but are declined because
their client is already receiving case management services. One case manager describes her frustration by stating:

“Mine (the aging resource) says that I’m primary, like when I call RSS or the Area on Aging, they say ‘these are services you would be providing, you can provide’. I mean other than coming out to change a level of care so that they can go into assisted living or a nursing home—but as far as their on going care I mean they’re really saying that we are the primary provider and that they don’t need to be involved.”

One traditional case managed team acknowledged that they have some valuable resources available to them but case managers are tied up dealing with the psychiatric crises of their other clients and generally don’t have the time to explore these resources. Another traditional case managed team also stated that they wish they had more time to explore aging-related resources, but they are prohibited because of the demands placed on them by all of their other clients.

**Social Supports:** A common frustration expressed by case managers dealt with the general lack of appropriate socialization activities or opportunities for older clients; there just isn’t a lot of Adult Day Care centers or other day programming available for their clients, making isolation a huge concern for older clients. In some cases, it appears that some Adult Day Care (ADC) centers either don’t accept clients because of their mental illness or because their health insurance (Medicaid) does not fund the service. Case managers also expressed that most of their clients are not appropriate for ADC centers because of their mental illness and/or increasing medical issues but there are not other alternatives. Most case managers expressed that an ADC center or senior group catered towards the older mentally ill client would be ideal and extremely beneficial in reducing the isolation of older mentally ill clients. Some case managers stated that there had been attempts in their city for this type of older adult programming but funding became an issue and these programs were discontinued. One case manager describes her frustration with this issue by stating:

“Groups—what kind of groups can you put somebody who’s 75 and the rest of them are in their 40’s and 30’s? My client enjoys groups but there are not other groups to give her, you know, because she is 75 and has a lot of health issues”
Lack of family and other support systems is another contributing factor to the increased isolation of older adults with mental illness. Often times the only source of support or companionship comes from the client’s case manager; this support is often limited to transportation to and from appointments, home visits to monitor mental health status, and ongoing treatment planning. If a client has no other family members or support persons to help with transportation, a client becomes very limited in the socialization opportunities that may exist out in the community. One case manager states:

“Our clients, especially by the time they reach that age, they have no family, they have no friends, they’re very isolated—the elderly, because they’re parents are gone and our younger clients have parents and they’re at least somewhat involved.”

Other: In addition to the five challenges previously discussed, other challenges or case manager issues were expressed during the focus groups. These challenges were issues concerning the death and dying of clients, the legal rights of clients, the age differences between case managers and older clients, and ethical dilemmas. Again, these are challenges that affect how case management services are provided to older adults with mental illness either with a specialized geriatric team or with a traditional team. Each team struggles with these issues to different degrees; issues affecting some teams more than other and vise-versa.

For one specialized geriatric case management team, death of clients is a frequent and common experience that case managers must face, plan for, and accept. Because they only provide services to older clients with mental illness and experience an average of three to five client deaths a month, they have added an agenda item called “Death”. This provides the case managers the opportunity to process their experiences and emotions concerning the death of a client and get support from their team and the team doctors. In some cases the case managers of this team help to coordinate funeral arrangements. This is most often done when the client no longer has any family support or friends who can make these arrangements.

A traditional case management team discussed their concerns regarding legal issues of clients, especially that of guardianship. One case manager stated that she was asked by the nursing home in which one of her clients resided to become the guardian of her client, so that she could sign for treatments that the client needed. The case manager stated that guardianship services are out of the realm of what she is able to provide her clients. Other case managers
expressed that often nursing homes assume that the case manager is acting as the guardian and can authorize certain treatments when this is clearly not the case. These case managers stated that they don’t know enough about guardianship issues, how to obtain guardianship, and would like more information about these and other legal issues.

Ethical dilemmas were another issue that was brought up a few times during focus groups. These issues highlighted the tension between a client’s right to self-determination and the case manager’s responsibility to intervene when the client’s safety is in jeopardy.

**Approaches to Case Management Services**

During each focus group with case managers and interviews with program managers/team supervisors, the question was posed “In your opinion, what is the best way to serve older adults with mental illness?” Regardless of the type of case management model (traditional or specialized geriatric teams), there was agreement by all teams that some type of specialized geriatric case management team would be the most effective and ideal way to serve older adults with chronic and persistent mental illness. This is not to say that those teams already providing specialized geriatric case management services are without challenges of their own. This is not to imply that those teams providing traditional case management services are in some way not meeting the needs of their older clients.

One team supervisor of a traditionally case managed team expressed that while a specialized geriatric team may be ideal, he didn’t like the idea of transferring a client from one case manager to another once they turned 55. His concern was that clients already experience so much case manager turnover due to the stressful nature of this kind of work and shifting to this type of model would only add to the amount of turnover. Another concern expressed by this supervisor dealt with funding and billing issues. He stressed that collaboration with medical doctors regarding medical issues and activities to increase socialization are typically services that are considered non-billable, again meaning that these are services for which Medicaid typically will not reimburse.

When these concerns were raised with the program manager of a specialized geriatric case management team her response was
“The reality is that case managers come and go all of the time. That is the reality. Sometimes unfortunately, come clients with the luck of the draw they get a pattern where they get case manager after case manager…”

She also stated that her programs are not receiving funding from any other sources other than Medicaid, Medicare and some private insurance. It was stressed that agencies need to find ways to get these services (recreation, socialization, medical collaboration) paid for, whether it’s finding ways to be creative with their billing so that it is not fraudulent, and/or working with the agency’s administration and board to get services billed under different funding streams such as the Mental Health board levy money. She stated that you have to be persistent and keep finding ways to let the administration know that these types of services are necessary while at the same time offering suggestions as to how to solve the problem. Sometimes they are receptive and sometimes they are not, but you have to keep trying.
CHAPTER IV

Summary

In review, the research questions for this study are: (1) What are the existing models of case management services to older adults with mental illness within Ohio community mental health organizations?, (2) What are the challenges case managers encounter while providing these types of services?, and (3) Is there an optimal approach to providing case management services to older adults with mental illness?

The information obtained from the focus groups conducted with five community-based case management teams, including either the program manager or team supervisor, shed some light on (1) the models of case management services utilized by agencies, (2) the challenges case managers are facing as they continue to provide services to an increasing and more medically fragile aging client case load and finally (3) indications for an optimal approach to providing case management services to older adults with mental illness. The key findings of this study highlighted five system challenges (transportation, housing, medical issues, community resources, and social supports) that affect how older clients are served. This chapter will explore reasons these five system challenges may be affecting the quality and effectiveness of those services, possible explanations for gaps in service, and implications for further study of this topic.

In this study of five Ohio community based mental health agencies, two were identified as providing specialized geriatric case management services. The other three teams provide traditional services in which there is an integration of services to all adults over the age of 18. When discussing the major issues affecting their older clients, case managers reported that older clients with mental illness experience an overall decline in physical health and an increase in the number of medical problems, which tends to complicate their psychiatric illness and stability. Increasing medical issues require routine medical follow-up and often times numerous visits to multiple medical professionals. The brunt of this responsibility lies on the mental health case manager. Coordination of care requires the scheduling and tracking of medical appointments, transportation to and from appointments, collaboration with physicians to coordinate treatment planning, monitoring of physical and mental health symptoms and safety concerns both in the home and in the community, and finally connecting clients to appropriate age-related resources
to help reduce isolation and improve socialization and integration into the community. These responsibilities exist for both case managers of specialized geriatric case management teams and those of traditional case management teams.

The difference in models suggests that specialized geriatric teams often have a multidisciplinary team, including a nurse, case aids, and peer support to assist case managers with medical appointments and general client support. Specialized teams also have the perceived advantage of focusing all of their training, education, and attention to age-related issues, learning opportunities, and community resources. In contrast, those teams providing traditional case management services usually do not have a multidisciplinary team nor case aides or peer support to assist case managers in getting clients to medical appointments. Thus, a great deal of case manager time is tied up in transporting clients to appointments, most of which is un-billable time. These teams also have the responsibility of providing services to clients of all age levels (usually over the age of 18) and managing varying degrees of psychiatric instability, leaving them little time for exploring age-related community resources, attending training and educational opportunities, nor the flexibility to address the specific social needs of their older clients.

Given these factors, most of the case managers from the focus groups, including most of the supervisors, expressed the view that a specialized geriatric case management team would be the best way to serve older adults with chronic and persistent mental illness.

**Implications**

It is clear that from a practice, policy and research perspective that there needs to be an integration of or a partnering between the aging network and the mental health system to adequately and effectively provide services to older adults with mental illness. “Studies have also shown that the use of specialized geriatric services and staff as well as partnerships between the aging and mental health systems can increase access to services for older persons” (Administration on aging, 2001 report, pg. 25). From a community based mental health agency perspective, the re-structuring or development of specialized geriatric case management teams seems like a very viable and necessary option.
Practice: The use of specialized geriatric case management teams appears to allow greater focus and attention to be given to the specific and very different needs of older mentally ill adults. A multidisciplinary team consisting of a nurse, geriatrician, case managers, case aides, and peer support can allow for the comprehensive treatment of older adults under the umbrella of community mental health services. Focusing on this population rather than a mixed caseload of clients seems to allow the specialized team to become experts in their understanding of how to serve older mentally ill clients. This specialized focus could allow professional the support to address needs more effectively and appropriately with the goal of improving both the medical and mental health of older clients, decreasing or postponing the placement of clients into Nursing home facilities, and improving the overall quality of life for these individuals. It is important to remember that older adults with life long mental illness are at a greater risk of medical complications. According to Bartels (2004), “The older person with SMI (severe mental illness) is subject to the double jeopardy of an increased risk of medical illness associated with advancing age in conjunction with the increased risks of medical illness associated with having a SMI. The cumulative long-term exposure to psychiatric medications with substantial metabolic and neurological side effects places the older person with SMI at greater risk of respiratory, cardiovascular, and endocrine disorders” (pg. S251). There is a clear advantage to having a specialized team knowledgeable about age–related medical problems, mental health symptoms, and the reciprocate affect these two have on each other in the holistic treatment of older adults with mental illness. As one program manager stated:

“The big thing is you need a holistic approach. You cannot treat an older adult in a vacuum. If their housing isn’t appropriate they’re going to end up back in the hospital, if they’re not doing well mentally, they can’t keep their apartment…There’s no way you can do psych stuff without looking at the medical…I mean you’re not just talking about a mind--can’t do one without the other.”

Another advantage to a specialized geriatric case management team would be the collaborative opportunities between case managers (mental health experts), the aging network (aging experts), and medical professionals (clinical, behavioral, and pharmacological experts). An Administration on Aging 2001 report states that an “affiliation of a CMHC (Community Mental Health Centers) with an Area on Aging was associated with more indirect services of all types
(e.g., consultation and education), more sites where mental health programs were offered to older persons, and more provision of direct services such as Alzheimer’s disease treatment and management, family support, and respite” (pg. 24).

All five case management teams have access to either a local county office on aging or Area Agency on Aging (AAA) within their cities. As indicated in most of the focus groups conducted with case managers and team supervisors, case managers are aware of these resources but in general have not found them to be particularly helpful. A specialized geriatric case management team could create a unique relationship with either the county level or regional aging network provider because of their mutual expertise and access to resources. In theory this relationship would eliminate gaps in service, create reciprocal training opportunities, and help these organizations to work together to provide services to older clients. This would require a shift in thinking from both the mental health agencies perspective and the aging network. Additionally, it would require re-examining how funds are utilized and advocating for a more integrated use of the different funding streams for each system (mental health and aging).

**Policy:** Within recent years, there has been an emerging recognition by both the federal and state governments that there is a growing need to better address the specific needs of older adults with mental illness. This can been seen in such reports as the President’s New Freedom Commission on Mental Health (2003), the Administration on Aging Report on Older Adults and Mental Health (2001), and the Surgeon General’s Report on Mental Health (1999). The key issue is funding and for most community based mental health centers a majority of their funding comes from Medicaid and the Mental Health Board, with a small portion coming from Medicare and private insurance. So much of what drives services to older adults with mental illness is determined by what is considered “billable services” under each of these funding streams. Unfortunately, the past few years have seen a rapid decrease in the range of allowable services that are provided to clients with many of them no longer considered appropriate. This has resulted in a decrease in reimbursable services for many community-based mental health agencies, requiring a shift in how mental health services are provided. This decrease has affected such services as medical collaboration, transportation, socialization activities, day programming, adult day centers, and others. Bartels and Smyer (2002) write “An increase in federal funding for services and outcomes research is necessary to establish best practices, medical utilization standards, and quality patient care” (pg. 18).
There is a need for constant modification of how policies are written that determines the allocation of funds to mental health agencies and the aging network. The more we learn about new treatment models and collaboration opportunities regarding older adults and mental illness the more there is a need to modify policies. Instead of looking at policies as stagnant rules that are set in stone, mental health and aging professionals need to look at them as malleable; shaping and re-shaping them as new information is learned. New research will continue to emerge bringing with it new information that can be put into policy.

This new research, although limited, supports the need for such services as specialized geriatric case management teams. The challenge comes for community-based mental health agencies to convince their board of directors and local mental health boards that these services are a necessity. This also requires a commitment on the part of both the mental health agencies and the mental health boards to reconsider how funding is allocated, allowing more flexibility in what are considered billable services. This flexibility would allow specialized geriatric case managers to provide more holistic services, addressing all needs such as socialization, transportation, collaboration with medical professionals; and the development of senior groups targeted towards older mentally ill clients. Perhaps an alternative funding stream that utilizes monies from both the aging and mental health networks would allow for a more comprehensive range of services to be created to better meet the needs of older adults with mental illness.

**Research:** As stated previously, little research has been done regarding how community-based mental health agencies are providing services to older adults with mental illness. Some important questions that still need to be asked include: What is keeping mental health agency directors from developing or shifting towards specialized geriatric case management services? How much training and education do mental health agencies offer their staff regarding the specific needs of older adults? How are some mental health agencies successfully able to implement a specialized geriatric case management team utilizing the same funding sources as other mental health agencies who state it’s not possible without additional funding? These questions could be explored with additional research that would allows researchers to delve more deeply into the inner workings of the mental health system and spend more time with each agency to focus specifically on training issues. Additionally, research could be done with an existing specialized geriatric team that is already showing success and develop best practices guidelines that could then be shared with other agencies wishing to convert to a specialized team.
**Limitations:** This study was completed with five case management teams from five different community based mental health agencies, all located within larger Ohio metropolitan areas. All of the responder agencies were providing comprehensive mental health services to adults, and all are receiving funding from the Ohio Department of Mental Health, Medicaid and Medicare. Clearly this study could be extended to include community-based mental health agencies in other states, but due to the limited time frame and limited resources, this study sample was chosen based on convenience of location and accessibility.

One of the major challenges encountered with this study was the reliance on gatekeepers, the program managers and/or team leaders for each case management team, in scheduling the focus groups and informing case managers regarding the purpose of this study. If this study were to be repeated, it is suggested that a consent form describing the nature and purpose of the study be distributed to all case managers by the program manager/team supervisor, signed and returned, prior to each focus group instead of being completed at the time of the focus group. This would allow each participating case manager more choice in whether or not they participated, a clearer understanding of the purpose of the focus group, and hopefully a more open discussion regarding the issue at hand.

**Conclusion**

There is still much to be studied and learned about how best to serve older adults with mental illness. This study of five community-based mental health case management teams helps to contribute to the limited but emerging knowledge base about older adults with chronic and persistent mental illness and how to best serve them within the mental health system. While this study is limited to five agencies in Ohio, it paints a clear picture of the types of challenges case managers are facing to provide effective and appropriate services to older adults with mental illness regardless of the type of case management model utilized by the agency. It is clear however that the few agencies that have successfully transitioned to a specialized geriatric case management team are having significant success that warrants further exploration. There is much to be learned from these teams in terms of best practices, effective and holistic treatment, and collaboration efforts with resources and medical professionals, especially geriatricians. It has been the intention of this study to take a closer look at how services are being provided to older adults with mental illness with the hope of increasing awareness to the importance of this
issue. By increasing awareness, the mental health system and agencies providing community-based mental health services should understand that it is critical that they begin focusing on specialized services to older adults with persistent and chronic mental illness.
References


Ohio Department of Mental Health. Retrieved March 5, 2005 From www.dwcubes.mh.state.oh.us.


Appendix A: Interview Guide #1

**Case management Services to Older Adults: Interview Guide**

1. If we could go around the room I was hoping each of you could give a brief example describing one of your most challenging and/or interesting cases? (limit time).

2. Describe the kinds of services you currently provide to older MI clients. What barriers are there to providing those services?

3. What is your opinion about the best way to provide services to older MI clients?
   a. Innovative approaches
   b. Team structure
   c. Collaboration with geriatric psychiatrists and physicians
   d. What works, what doesn’t work with current structure?
Appendix B: Interview guide #2

**Interview Guide (for Team supervisors/coordinators)**

1. Can you tell me about the case management team you supervise?
   - Structure
   - Number of CMs
   - Qualification
   - Dedication/commitment to quality service

2. Tell me about some of the issues/challenges your case managers face in working with older MI adults?
   - Collaboration with other aging networks
   - PCP’s

3. Help me understand some of the issues/challenges you face as a supervisor in this agency with regards to services to older MI clients?
   - Agency outcomes
   - Future direction of services

4. What is your opinion about the best way to provide services to older MI clients?
   - Innovative approaches
   - Team structure
   - Collaboration with geriatric psychiatrists and physicians
Appendix C: Phone screen form

Phone Screen Questionnaire

Date________________________

Name of Community Mental Health Agency______________________________________

Name/Title of Person Interviewed on Phone______________________________________

1. Do you provide specialized geriatric case management services? YES____ NO____

   a. If yes, briefly describe how those clients are served.

   b. If no, briefly describe how your older SMD clients are served.

2. What is your total agency client census?______________________________________

3. How many clients do you currently have who are over the age of 55?______ % over
   55____

4. Does your agency have established outcomes focused on the needs of your older
   SMD clients? YES_____ NO_____  

   a. If yes, what are those outcomes?

   b. If no, how are services to older SMD clients measured?

5. How familiar are your CM’s with services for OA in the community?
Dear (Agency Contact):

This letter is a follow up to the phone conversation we had regarding my interest in meeting with you to talk about your agency and case management team for my master’s thesis.

Let me introduce myself to you once again. I am a graduate student at Miami University in Oxford, OH working towards my master’s degree in Gerontology. My thesis focus is on how community mental health agencies in Ohio are providing case management services to their aging (over 55 years of age) mentally ill clients.

As I indicated before, I’d like to come visit your agency and meet with you as well as the team you supervise. My hope is to do a focus group with your case managers, probably lasting about an hour, just to talk with them about the services they provide and any issues, concerns, or suggestions that they may have regarding their work with aging and older mentally ill clients in your community. I would also like to meet with you individually to discuss agency specific outcomes, how your team functions to serve older clients, and any issues, concerns, or suggestions you may have regarding this population.

If a visit is possible, along with the focus groups, I am interested in obtaining the following information regarding your agency:
- Total agency client census
- Number of active clients over the age of 55 years
- Some examples of agency outcomes related to client care and quality of services

Please know that all participation is voluntary and all responses will remain confidential.

If you could please respond either by email or phone so we can schedule a date and time for a visit, it would be greatly appreciated. I am hoping to make these visits at the end of January and early February if possible.

Thank you very much and I look forward to meeting with you and your team.

Sincerely

Rachel Tomsic
Graduate Student-Masters in Gerontology
Miami University Oxford, OH
Email: tomsicra@muohio.edu
Phone: 513-885-7567
Appendix E: Consent form

Consent to Participate

I understand that I am participating in a study that seeks to understand how case managers/case workers within a community mental health center provide services to aging and older severely mentally ill clients. This discussion will include the types and quality of services provided to clients by the agency, mental health system, and case managers/case workers.

I understand that my participation in a group discussion is completely voluntary. Everything that is being said in the discussion group will be confidential, and no written reports, publications, or presentation will include anything that might identify me. I also understand that my supervisor will not be present and anything that I say regarding the quality of my work or others will not be used as an evaluative technique. If my words are quoted, they will not be linked to me in any way.

I understand that if I become tired, or uncomfortable, or do not wish to continue, I may withdraw from the discussion group at any time and for any reason. I am giving my consent to participate freely, and with full understanding. In addition, I am also giving my permission to be audio taped.

I understand that I may contact the Office for the Advancement of Research and Scholarship (513-529-3734) or <humansubjects@muohio.edu> for questions about my rights as subjects.

I understand that if I have any questions regarding this project I can contact Rachel Tomsic as the principal investigator by email at tomsicra@muohio.edu or by phone at 513-529-1858. I may also contact Rachel Tomsic’s advisor on this project, is Dr. Robert Applebaum. His email address is applebra@muohio.edu or he can be reached by phone at 513-529-2632.

Thank you.

Signed________________________________  Date_________________