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Perceived need of mental health care identified residents, administrators, and direct care staff of an assisted living facility

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Perceived Need of Mental Health Care Identified Residents, Administrators, and Direct Care Staff of an Assisted Living Facility

by

Clarissa Nicole Gayer

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Graduate Department of Clinical Psychology
George Fox University
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Perceived Need of Mental Health Care Identified

Residents, Administrators, and Direct Care Staff of an Assisted Living Facility

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Approval

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Abstract

This study intended to determine whether there was disparity between the mental health needs of residents and the awareness of those needs by administrators and direct care staff of an assisted living facility (ALF). This study used the Center for Epidemiologic Studies Depression Scale, Generalized Anxiety Disorder Scale, and Schedule for Affective Disorder and Schizophrenia for School Aged Children-Lifetime Version to assess 25 randomly selected residents for symptoms of anxiety or depression. The 7 administrators and 11 staff of the ALF where the residents lived were asked to complete a semi-structured interview, determining their perception of depression and anxiety in each of the participating residents. The results reveal that the administrators and staff of the ALF tend to overestimate the symptoms of depression and anxiety among the participating residents. Interestingly, according to the assessment instruments, the majority of participating residents exhibited a sub-clinical level of symptoms, and only a few met the criteria for a diagnosis. The semi-structured interviews revealed 2 themes of protective
factors for many residents’ faith and family support. The data also suggest that despite the staff’s perception of mental health concerns among the residents, the ALF is deficient in offering or providing appropriate services. This disparity between the perceived mental health needs of the ALF residents and the services provided by the ALF needs to be addressed. The implications for future research and policy include further examination of how to engage ALF residents in mental health services, particularly if the administrators and staff are aware of a resident’s symptoms.
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Chapter 1

Introduction

Overall Objective

The goals for this project were (a) to estimate the number of Assisted Living Facility (ALF) residents who had symptoms of anxiety and depression that went unrecognized and untreated, and (b) to determine the extent to which the staff and administrators of the ALF recognized or were aware of mental health concerns of the residents.

Specific Aims

In order to prevent premature discharge from ALF to higher levels of care, depression needs to be recognized and treated as early as possible (Chapin, Dobbs, Hayes & Hickey, 2002). Parmalee, Katz, and Lawton (1989) indicate the prevalence of major depression in residents of long term care facilities to be 12.4% with an additional 30.5% of residents displaying less severe, yet still clinically significant depressive symptoms. However, there are common barriers that prevent older adults from seeking mental health treatment or even expressing mental health concerns, including stigma, a lack of understanding, and fear (Harman & Reynolds, 2000; Yang & Jackson, 1998). It was hypothesized that residents of ALFs would underreport their anxiety symptoms on the Generalized Anxiety Disorder Scale (GAD-7) and their depressive symptoms on the Center for Epidemiologic Studies Depression Scale (CES-D), but would reveal more symptoms in the Schedule for Affective Disorder and Schizophrenia for School Aged Children-Lifetime Version (K-SADS-PL); while administrators and staff of ALF would underestimate the
need by residents for mental health care. This discrepancy would indicate a necessity for assessment, education, training, and communication of mental health needs in older adults of ALF, which correlates to needed treatment.

**Specific Aim 1.** Symptoms of anxiety and depression are prevalent in ALF residents (Morgan, Gruber-Baldini, & Magaziner, 2001; Wagenaar, Mickus, Luz, Kref, & Sawade, 2003). The Administration on Aging (2001) found that between 15-25% of older adults in long term care facilities are depressed. Data obtained in the 1985 National Nursing Home Survey indicates that 65% of older adults residing in institutions require mental health services yet are not receiving such services (Burns & Taube, 1990). While some older adults may enter an ALF with a previous mental health history; this is not true for the majority (Administration on Aging, 2001). There are additional unique dynamics such as the developmental stage of life, environmental factors, grief and loss, diminishing mental capacity, and limited social interactions, all of which can contribute to anxiety and depression for the older adult. The residents of the ALF were asked to complete the CES-D, GAD-7, K-SADS-PL, and responded to a semi-structured interview to determine if any of the residents experienced symptoms of anxiety or depression and whether any barriers to mental health service were present and identified.

**Specific Aim 2.** Currently there are several discrepancies in mental health care policies for older adults in ALFs. There are more interventions present in nursing homes (NHs) than in ALFs at this time because NHs are regulated by the federal government; while ALFs are either privately owned and operated, nonprofit, or for-profit organizations and are all administered without federal regulation. The state regulation of ALFs vary tremendously and as a result there are no standardized education or training programs which administrators and staff are required to
complete prior to or during employment at an ALF (Mollica, 2002). The staff and administrators of the ALF were asked whether each of the 25 participating residents exhibited symptoms of anxiety or depression and then also completed a semi-structured interview to determine their awareness of mental health symptoms, level of education, and training of the personnel at the particular ALF.

Specific Aim 3. Recommendations were provided to the ALF so that the staff and administrators would be able to better serve and care for the residents in the future.

Background and Significance

Mental health in older adults. Mental health concerns can be present in any developmental period, including in older adults; although much of the current research and treatment modalities overlook this population, particularly those in assisted living facilities (Cummings, 2002). The lack of attention to mental health in the elderly is becoming an increasingly significant problem as the total number of older adults is continually growing. One study has shown that within ALFs and NHs the number of residents experiencing dementia, depression, or other psychological disorders was approximately 66% to 81% (Gruber-Baldini, Boustani, Sloane, & Zimmerman, 2004). Regardless of the significant losses that are a part of the aging process, anxiety and depression are not a “normal” part of aging and need to be treated (Davis, 1996; Hyman, 2001; Zarit & Zarit, 2007).

Depression in older adults may manifest itself differently than it does in other developmental phases (Roose & Sackeim, 2004). Older adults tend to exhibit somatic symptoms that may not fit within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association [APA], 2000) criteria for a diagnosis of major depression
(Davis, 1996; Smyer & Qualls, 1999). Specifically, among older adults the symptoms of depression often overlap and are comorbid with physical complaints that are difficult to differentiate (O’Hara, Coman, & Butters, 2006). These symptoms include: stomach aches, social isolation, decreased energy and increased fatigue, trouble concentrating, alcohol and drug use, insomnia or other sleep disturbances, changes in appetite, and loss of interest in events once thought pleasurable (Lenze, Karp, Benoit, Mulsant, Blank, & Shear, et al., 2005; Roose & Sackeim, 2004). “Exaggeration of and preoccupation with physical problems and exaggeration of personal helplessness are signs of depression” (Goldfarb, 1974, p. 243)

Clinicians and researchers believe that the *DSM-IV-TR* (APA, 2000) diagnostic criteria are limited in application to late life depression (Hyman, 2001), are age biased, and strict adherence is not necessarily appropriate (Newmann, 1989). Blazer (1994b) found that neither the criteria for major depressive disorder nor dysthymia capture the majority of older adults who have clinically significant depressive symptoms. Blazer (1994a), as a result, argues that the “prevalence of late-life depression depends on the definition of the disorder. One definition alone does not adequately capture the construct. Therefore, epidemiologists have concentrated on two basic definitions of cases: clinically significant depressive symptoms and clinical depression” (p. 10). Mild, yet chronic, depressive symptoms are common in older adults (O’Hara et al., 2006; Roose & Sackieim, 2004).

Anxiety is frequently seen in conjunction with depressive symptoms in older adults (Cook, Orvaschel, Simco, Hersen, & Joiner, 2004; Lenze et al., 2000; Parmlee, Katz & Lawton, 1993). In fact, Lenze et al. (2001) found that somatic complaints occurred more frequently in comorbid anxiety and depression disorders than in just anxiety or depressive disorders alone.
Some somatic complaints, such as gastrointestinal distress, pain, and fatigue are often associated with anxiety disorders and it has been theorized that these somatic complaints may be easier for the person to manage and understand, rather than the psychological concerns (Lenze et al., 2005).

When anxiety or depression goes undiagnosed and untreated it will not go away or get better. Bruce and Leaf (1989) found that the odds of dying from a mood disorder over a period of fifteen months in a person over 55 is four times greater than other subjects –controlled for age, gender, and physical health. Death as a result from a mood disorder can occur as a suicide. Caucasian men over the age of 65 have the highest rate of suicide, six times the U.S. average (Hyman, 2001; Zarit & Zarit, 2007). Untreated depression can also result in behavior problems in the older adults (Gruber-Baldini et al., 2004). This then leads to an increase in medical costs and often early or premature discharge into nursing homes. Several studies have found that residents of ALFs are twice as likely to be discharged into higher care facilities if their mental health is not factored into treatment (Chapin et al., 2002; Dobbs, Hayes, Chapin, & Oslund, 2006).

Primary Care Physicians (PCPs) often under-diagnose depression in older adults (Administration on Aging, 2001). Moreover, research has found that despite a diagnosis of depression made by a PCP, the PCP frequently does not provide appropriate treatment (Cummings, Chapin, Dobbs, & Hayes, 2004; Harman, Crystal, Walkup, & Olfson, 1999; Nutting et al., 2002). One study found that patients with depression that are only treated by their PCP held a negative attitude in regards to mental health care rather than those treated by a mental health specialist (Van Voorhes et al., 2003).
**Assisted living facilities.** ALFs are the most rapidly growing category of residential care facility, providing care at a level in between independent living and NH and it is more cost efficient than NH (Cummings, 2002; Jang, Bergman, Schonfeld, Molinari, 2006). These facilities are defined as “residential settings that provide personal services, 24-hour supervision and assistance that is able to meet scheduled and unscheduled needs, activities and health related services; designed to minimize the need to move, designed to accommodate individual residents’ changing needs” (Assisted Living Quality Coalition, 1998, p. 65).

Meyer (1998) estimated that by the year 2010 there will be more residents in ALFs than in NHs. The focus of ALFs tends to be on the physical needs of the residents, rather than on the entire person, including the psychological (Cummings, 2002). The majority of ALFs, unlike NHs, do not have social workers, psychologists, and nurses who receive mental health training (Cummings et al., 2004). The Omnibus Budget Reconciliation Act (OBRA) legislates that long term care facilities (LTCF) are required to address the psychological needs of their residents (Molinari, 2000), however ALFs are not considered LTCFs. Nor are the ALFs under federal regulations that keep NHs accountable to regulations at a state level that require that mental health needs of residents be addressed (Mollica, 2002).

Previous studies have examined the perspectives of the administrators (Cummings et al., 2004; Wagenaar et al., 2003) and residents (Chapin, Reed, & Dobbs, 2004; Jang et al., 2006; Morano, & DeForge, 2004), regarding mental health care, however, the staff who spend the most time with the residents have not been surveyed regarding their awareness of mental health issues. Mollica (2002) found that only 16 states require that mental health information to be incorporated into staff training. A lack of awareness, knowledge, and training in recognizing
mental health concerns leads to a lack of treatment of these problems in the residents of ALFs (Chapin et al., 2004; Dobbs et al., 2006).

The Administration on Aging (2001) found that less than 3% of all older adults utilize psychological care from a mental health professional and only half of older adults who admit they have problems get help. The underutilization of mental health services may be primarily due to various barriers. One such barrier is the cost of treatment and the older adult’s inability to pay for services due to Medicare’s restriction on services. There are significant out of pocket costs for mental health care for all Americans, but particularly for older adults (Harman & Reynolds, 2000; Wagenaar et al., 2003).

An additional barrier that is particularly detrimental is the stigma associated with mental illness resulting in a fear of acknowledging the need for mental health services (Wagenaar et al., 2003; Yang & Jackson, 1998). The current generation of older adults have not been educated or exposed to mental health services except in extreme circumstances, e.g. commitments to psychiatric facilities and over-medication (Hawes, Rose, & Phillips, 1999). The majority of older adults have not been exposed to newer psychological treatment modalities so they are unaware that mental health care is designed for the purposes of aiding in mental health (Becker, Stiles, & Schonfeld, 2002; Harman, & Reynolds, 2000; Yang & Jackson, 1998).

Mental health concerns are not limited to the psychological effects; these problems can also affect the person physically. Diabetes, heart disease, vascular disease, Parkinson’s, Alzheimer’s disease, decreased immune function, and substance abuse are all correlated with depression (Alexopoulos, 2005; Roose & Sackeim, 2004). Research suggests one’s mental health can remain stable, despite failing physical health if one holds a positive attitude. The opposite is
also true (Jang et al., 2006). An early detection of depression can be an indicator of future dementia. Research reveals that Alzheimer’s patients displayed depressive symptoms two years prior to onset of dementia compared to those who did not develop dementia (Green et al., 2003). Often untreated mental health problems result in behavioral problems, e.g. wandering, pacing, and restlessness and can escalate into aggressive behaviors, hitting, sexually inappropriate behavior, verbal abuse, etc (Gruber-Baldini et al., 2004; Wagenaar et al., 2003). Cummings et al. (2004) found that until a person’s behavior becomes problematic, their mental health is often ignored.

One of the most popular concepts in gerontology is “aging in place.” Dobbs et al. (2006) explain, “this philosophy is that facilities adjust their service provision and level of care criteria to meet residents’ changing needs and thereby avoid discharging individuals to a higher level of care such as a nursing home” (p. 614). Aging in place has been shown to be a challenge for individuals suffering from mental health concerns that go undiagnosed and untreated (Dobbs-Kepper, Chapin, Oslund, Rachin, & Stover, 2001). In fact these individuals are forced to enter into care facilities prematurely, with additional care provided that is in turn more costly and often not necessary (Chapin et al., 2002; Wagenaar et al., 2003). Mental health symptoms should be addressed because of the financial, psychological, and physical costs to individuals and communities.

The denial of symptoms combined with a lack of awareness, lack of insurance benefits for psychological needs, increasing out of pocket costs, transportation concerns, and confidentiality concerns creates many barriers to services (Chapin et al., 2004; Lebowitz et al., 1997; Morano & DeForge, 2004). Yang and Jackson (1998) found that ways to move past the
barriers are to educate, build a strong rapport, reframe any psychological jargon, define terms in language that is friendly and understandable, and address any concerns or hesitations a person may have. Support can be provided in various ways, including having a telephone or home visit as opposed to traditional therapy sessions, implementing a sliding scale or accepting Medicare and Medicaid insurances, conducting support groups, and coordinating care with the patient’s primary care physician.

Alliance with the primary care doctor may be essential, because currently the primary care doctors are the principal providers of health care to older adults; diagnosing mental health concerns as well as physical complaints (Administration on Aging, 2001; Coyne, Thompson, Klinkman, & Nease, 2002). Due to the limited time a patient has with his or her physician, older adults’ complaints of physical symptoms are often addressed and treated prior to any psychological concerns are even explored. It is becoming evident that modifications to current methods of assessment and treatment of mental health issues are needed to meet the needs of older adults (Administration on Aging, 2001; Alexopoulos, 2005; Cummings, 2002).

Administrators and staff of ALFs cannot presume that the resident’s physician meets their emotional needs. As stated previously, the requirements by both local and federal governments are not as stringent for ALF in comparison to NH; as a result the quality of education, training and screening varies greatly.

Cummings et al. (2004) reported that fewer than half of all ALFs surveyed in Tennessee and Kansas conducted a mental health assessment of the residents at intake and even fewer screened after this initial screen. There was a correlation among the facilities indicating that those that provided mental health screens also had high rates of mental health training and fewer
reported mental health concerns. However, typically the staff in both ALFs and NHs are overworked, underpaid, and not supported by the administrators. The Health Care Financing Administration (HCFA) Nursing Home Staffing Study found that “more than half of the nation’s nursing facilities (54%) were below the suggested minimum staffing level for nurses’ aides, and nearly one in four (23%) were below the suggested minimum staffing level for total licensed staff” (Administration on Aging, 2001, p. 37).

The morale and attitudes of the workers will affect the treatment of the residents and influences the interactions between the residents and staff. If all ALFs had a standardized education plan with respect to mental health concerns, adequate training of the staff, and administrative support for all staff members, an environment would be created in which the residents feel supported, and get more adequate mental health care. As studies have found with dementia patients (Maust et al., 2006; Zimmerman et al., 2005) there is a general lack of awareness of symptoms among the staff and many were unable to identify minor impairments without major behavior problems.

Researchers have yet to gather data directly from older adult residents of ALFs or have a standard method of assessment of mental health concerns. The resident’s fear and lack of knowledge of mental illness, and their personal assessment of their mental health needs have yet to be studied (Wagenaar et al., 2003). One study that examined the lives of individuals suffering with early stages of dementia interviewed the actual individuals asking how they experienced life with dementia (Holst & Hallberg, 2003). Research has focused more upon the caregivers of older adults and the psychological effects of caring for an older adult; rather than studying the emotional effects of aging and the tremendous loss experienced by older adults.
The implication of this is discussed by Chapin et al. (2004).

It is vital to increase awareness about the need for, availability of, access to, and benefits of mental health services for older adults in assisted living; and addressing mental health issues of assisted living residents has important implications for aging in place and for cost savings. (p. 360)

The current study intended to determine whether there were disparity between the mental health needs of residents and the awareness of those symptoms and needs by administrators and direct care staff of an ALF. This study also attempted to determine if residents do not seek out mental health services because of barriers associated with mental health care, and as a result the administrators and staff of the ALF do not offer mental health services because they are not an expressed need by the residents.
Chapter 2

Method

Purposes of This Study

Aim 1. The first step was to assess the mental health needs of the residents of the ALF; in order to identify any clinically significant anxiety or depressive symptoms. This was established through the administration of the CES-D, GAD-7, and the clinical interview of the K-SADS-PL, with minor age appropriate modifications. Also determined the available mental health resources to the residents and if these services are being utilized.

Aim 2. The second step was to assess if the staff and administrators of the ALF are aware of the mental health symptoms and needs of the residents.

Participants

A list was compiled of ALFs in the Portland, Oregon metro area (Appendix A); from this list the Marquis Vintage Suites ALF was selected at random to participate in this study. Twenty-five residents from Marquis Vintage Suites ALF in Woodburn, Oregon participated in this study. Of the 25 residents who participated, 20 were female and 5 were male. The average age of the participants was 85 years old. There were 23 Caucasian participants, one African American participant, and one Indian participant. Seven of the participants were married, four were divorced, and 14 were widowed. The average education level was a high school diploma. The average length of stay at this facility is two years.
Each of the seven administrators from Marquis Vintage Suites ALF in Woodburn, Oregon participated in this study. Of the seven administrators, six were female and one was male. The average age of the administrators was 30 years old. There were five Caucasian, one Hispanic, and one Pacific Islander administrators surveyed. The average level of education was some college. The average length of employment at any ALF was seven years and the average length of employment at the surveyed Marquis Vintage Suites ALF was three years.

Each of the 11 staff from Marquis Vintage Suites ALF in Woodburn, Oregon participated in this study. Of the 11 staff, 10 were female and one was male. The average age of the staff was 26 years old. There were six Caucasian and five Hispanic staff surveyed. The average level of education was a high school diploma. The average length of employment at any ALF was over three years and the average length of employment at the surveyed Marquis Vintage Suites ALF was 16 months.

**Recruitment methods.** Each resident, staff, and administrator was given an opportunity to participate in this study.

**Inclusion/exclusion criteria.** Inclusion Criteria:

- Adult who is a resident of the Marquis Vintage Suite ALF.
- Caregiving staff or administrating staff of the Marquis Vintage Suite ALF.
- The resident, administrator, and staff must have the ability to read English at the 6th grade level by his or her report (current reading level of CES-D and GAD-7).

Exclusion Criteria:

- Any incomplete interviews, CES-D, or GAD-7 screeners were excluded from this study.
Participation enrollment. All administrators and staff that expressed interest and the randomly selected residents were provided with the study details and reviewed in entirety with the evaluator, including the eligibility requirements and consent process. Each participant was informed of the American Psychological Association ethical guidelines that state participation is voluntary and anyone can withdraw from the study at any time, prior to data entry without consequences. Following a review of the signed consent form (see Appendix B), the residents were given the CES-D and GAD-7. The residents were instructed to give their best estimate of how often they have observed the listed behaviors in their own life over the last week in the CES-D and the last two weeks for the GAD-7. These two assessment screeners were followed by the K-SADS-PL a semi-structured clinical interview.

Following the review of the consent procedures (see Appendix B), the staff and administrators were asked their perceptions of the mental health of each of the participating residents. Specifically whether or not the staff and administers recognized any anxiety or depressive symptoms the resident displays. The administrators and staff were asked to answer additional questions comprising the semi-structured interview (see Appendix C and D).

Measures

Demographic information was taken from the semi-structured clinical interview and developed semi-structured interview (Appendix E). The information collected from the residents included: participant’s age, gender, racial/ethnic group, marital status, and amount of time in the ALF. The information collected from the administrators and staff included: age, gender, racial/ethnic group, level of education, length of employment by the ALF, and length of employment as a care provider.
**Depression symptoms.** The CES-D (see Appendix F) has been used to assess depression in community samples of adults and has been found effective in older adults (Lewinsohn, Seeley, Roberts, Allen, 1997; Radloff, 1977). The CES-D is a self reported depression screener with 20 items that measure the severity of depression present (Radloff, 1977). The CES-D is easy to administer with little training required and this screener could be utilized by ALF to screen for initial depressive symptomology or changes in symptoms over time (Haringsma, Engels, Beekman, & Spinhoven, 2004). Studies suggest that the CES-D may be more discriminate than the BDI with individual differences in depressive severity (Santor, Zuroff, Ramsay, Cervantes, & Palcios, 1995). The CES-D was found to be a more effective measure compared to the Geriatric Depression Scale (GDS) with diverse populations and is more culturally sensitive (Mui, Burnette, & Chen, 2001).

The CES-D measures level of depressive symptoms in the previous week with scores above a cut off of 16 indicating depressive symptomology (Myers & Weissman, 1980). “Using 16 as the cut-off, sensitivity for major depression was 100%, while specificity was 88%” (Beekman et al., 1997) and this study also shows this assessment is not as sensitive for screening for anxiety. The psychometric properties of the CES-D are favorable with internal consistency of 0.85 in general population and 0.90 in psychiatric patients, moderate test-retest stability with correlations ranging from 0.45 to 0.70, excellent concurrent validity with clinical and self-report criteria, and evidence of construct validity (Radloff, 1977).

**Anxiety symptoms.** This study is limited to measuring anxiety symptoms of GAD. The GAD-7 (see Appendix G) screener was used to identify any anxiety symptoms in the participants. The GAD-7 is a brief measure that has been used to assess anxiety in community
samples of adults (Spitzer, Kroenke, Williams, & Lowe, 2006). It is a self-reported assessment that consists of seven items that are consistent with the DSM-IV-TR symptoms of GAD. The GAD-7 internal consistency is 0.92, with a reliability and validity of 0.83 (Spitzer et al., 2006). A cut off point of 10 is used to determine level of GAD symptomology with sensitivity at 89% and specificity at 82% (Spitzer et al., 2006).

Currently there is no assessment or scale that measures directly from the older adult’s perspective their perceived mental health concerns, especially in such a way to avoid stigmatizing language. In turn the K-SADS-PL a semi-structured interview, with age appropriate modifications, was used to gather this data. There was an additional semi-structured interview for the residents (see Appendix E) that asked demographic information, explored mental health concerns, and determined if the resident’s mental health needs are being recognized and met by the ALF.

A semi-structured interview (see Appendix C and D) was implemented with the administrators and staff of the ALF. The interview was used to assess the mental health services provided by the ALF, whether or not the staff and administrators perceived the residents mental health needs, if the needs are being met, and what mental health training is offered if any.

**Procedure**

Each randomly selected resident was asked individually if he or she would be willing to talk with the researcher and answer a few questions, including responding to the CES-D and GAD-7. The residents was given and asked to complete an informed consent, detailing the process of the interview and then their remaining questions about the study were addressed. The residents were interviewed individually by the researcher and debriefed after completing the
interview. The residents were given and asked to complete the CES-D and then the GAD-7. If a resident was unable to physically complete the assessment, the interviewer read it to the resident and marked the resident’s verbal response on the form. The interviewer then engaged the resident in the K-SADS-PL semi-structured clinical interview. While attempting to establish and maintain rapport with the resident, the interviewer completed the background and history, depressive disorders, and generalized anxiety disorder sections of the interview. At the end of each interview, referrals were given to local and national crisis lines that are toll-free and always available. If there were any current suicidal ideations or other assessed risks, the resident’s PCP and staff were notified.

Staff and administrators were asked individually if they would be willing to answer a few questions that took no longer than 10 minutes to complete. The staff and the administrators were interviewed separately and individually. Each was asked to read and sign an informed consent before answering any questions. The staff and administrators were asked to identify any anxiety or depressive symptoms of the participating residents; as well as about the mental health services and training provided by the ALF. After the staff and administrators completed the interview they thanked and were provided with any additional information they requested.

Demographic data were collected, including gender, age, race or ethnicity, marital status, length of time living at the ALF, and veteran status. The medical history, including a diagnosis of dementia and any medical condition, was collected. Confidentiality and its limits were reviewed with the participants. Participants were informed that this process was entirely voluntary and refusal to participate would not affect the provision of care for them at the ALF. The participants were interviewed in a private room. The majority of the interviews were
completed in approximately 40 minutes. At the end of the interview the participants were offered referrals to Lifeworks Northwest. If urgent risk issues, such as suicidality, were present the PCP and staff were notified. All of the interviewing was done by the primary investigator (PI); the PI assessed the symptoms of anxiety and depression of the 25 residents of the ALF on a scale of 1 (*no symptoms*) to 7 (*severe symptoms*). In addition, an inter-rater review of the symptom determination was conducted by three additional professional who work with older adults.

**Inter-rater reliability.** The PI has a Master’s degree in Clinical Psychology and 12 years of geriatric experience. The first rater earned her Master’s degree in community counseling and has 8 years experience working with older adults. The second rater is a registered nurse and has 23 years experiencing working with older adults. The third rater earned her PhD in Human Development and Family Studies with an emphasis in Gerontology and has 14 years experience in working with older adults.

The raters and the PI rated 15 participants from the day treatment program at which all four professionals are involved. The rater’s measure of agreement with the PI was high; Kappa = 0.90. The first rater’s measure of agreement with the PI was measured at Kappa 0.91. The second rater’s measure of agreement with the PI was measured at Kappa 0.95. The third rater’s measure of agreement with the interviewer was measured at Kappa 0.85. The overall rater’s measure of agreement with the PI was measured using a Kappa coefficient. The high inter-rater reliability (Kappa = .90) verifies competency of the PI and qualifies the PI’s rating of the residents of the ALF in the current study.
Chapter 3

Results

It was hypothesized that the residents, staff, and administrators at the ALF would underestimate the rates of anxiety and depression among the ALF residents. The ALF residents who were identified by the residents, staff, and administrators as depressed are shown in Table 1. The standard against which these depression judgments were compared was the decision of a psychologist, the PI, of the presence or absence of depression in the residents; these judgments are also shown in Table 1. The anxiety scores for each resident as judged by the residents, staff, administrators, and PI are shown in Table 2.

The PI based her judgments of the presence of anxiety and depression on the results of a structured clinical interview (K-SADS-PL). The anxiety score for each resident could range from 1-7; likewise, the depression score for each resident could range from 1-7. According to the PI, the majority of participating residents exhibited a sub-threshold level of symptoms. Specifically, only 9 of 25 residents (36%) met the clinical cutoff for anxiety diagnosis (a score of > 5) and 13 of 25 residents (52%) met the PI’s cutoff (a score of > 5) for depression diagnosis; among these, only 2 met criteria for both anxiety and depression. The percentage of residents’ judged to be significantly depressed and anxious by staff, administrators, residents, and the PI are shown in Figure 1.
Table 1.

*Depression Scores for Each Resident Judged by Staff, Administrators, Residents, and the PI*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Staff</th>
<th>Administrator</th>
<th>Resident’s</th>
<th>PI</th>
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Table 2.

Anxiety Scores for Each Resident Judged by Staff, Administrators, Residents, and the PI

<table>
<thead>
<tr>
<th>Participant</th>
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<th>Resident’s</th>
<th>PI</th>
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</table>
Scores on the CES-D were used as a measure of each resident’s estimation of his or her own level of depression and the GAD-7 scores were used as the resident’s self-report of anxiety level. According to the assessment instruments, the majority of participating residents exhibited a sub-threshold level of symptoms. Specifically, only 1 of 25 residents (4%) met the clinical cutoff (a score of 10) for anxiety diagnosis and 10 of 25 residents (40%) met the clinical cutoff for depression diagnosis (a score of 16); among these, none met criteria for both anxiety and depression. Thus, as expected, the residents underestimated their own symptoms of anxiety and depression, supporting the hypothesis.

Each administrator and staff member made a yes-no judgment regarding the presence of anxiety and depression based on their knowledge of the residents. The numbers reported in Tables 1 and 2 represent the number of staff (out of 11) and administrators (out of 7) who judged
a resident to be depressed or anxious, respectively. According to the administrators, the majority of participating residents exhibited a sub-threshold level of symptoms. Specifically, only 7 of the 25 residents (28%) had 5 or more administrators agree they were anxious and 4 of 25 residents (16%) had 5 or more administrators agree they were depressed; among these, three met criteria for both anxiety and depression. According to the staff, the majority of participating residents exhibited a sub-threshold level of symptoms. Specifically, only 8 of 25 residents (32%) had 8 or more staff agree they were anxious and 5 of 25 residents (20%) had 8 or more staff agree they were depressed; among these, only 4 met criteria for both anxiety and depression. For only 2 of the residents did the staff, administrators, and PI agree that the individual was depressed and the sources only agreed on the decision about anxiety for 1 resident.

The judgments of residents’ depression and anxiety by staff, administrators, residents, and the PI were standardized and then the standardized z-scores were correlated. These correlations are shown in Table 3. The resident’s strong correlation of 0.63 and the administrator’s strong correlation of 0.60 (Table 3) between ratings of depression and anxiety indicated their inability to differentiate anxiety and depressive symptoms. The PI’s moderate correlation of 0.42 (Table 3) between anxiety and depression indicated the PI was more able to differentiate between anxiety and depressive symptoms. The administrator and staff ratings of depression correlate strongly at 0.59 (Table 3) and anxiety at 0.58 (Table 3), indicating their ratings and judgment of both anxiety and depressive symptoms in the residents are similar.

There is no significant difference in the correlation between the PI and the staff or administrators when all the residents are rated and when only the residents known to the staff are rated, $t(16) = 0.15, p = .89$ (Table 1). There is no difference in the mean correlation between the
PI and the staff or administrators when anxiety and depression are rated for all the residents, \(t(17) = -1.02, p = .32\) (Table 1). Some residents are known better by staff than administrators and some residents are known better by the administrators than by the staff. There was no significant difference in how the staff and administrators rated the residents.

Table 3

*Correlations of Anxiety and Depression Judgments by ALF Staff, Administrators, Residents, and PI*

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<th>Judgments Converted to z-scores</th>
<th>Staff Dep</th>
<th>Staff Anxiety</th>
<th>Admin. Dep</th>
<th>Admin. Anxiety</th>
<th>Resident Dep</th>
<th>Resident Anxiety</th>
<th>PI Dep</th>
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<td>.41*</td>
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<td>R .58**</td>
<td>.59**</td>
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<td>.002</td>
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<tr>
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<tr>
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<td>R .29</td>
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<td>R .29</td>
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<td>.03</td>
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<td>.16</td>
<td>Sig .46</td>
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*Note.* Dep means Depression. ** Correlation is significant at the 0.01 level (2-tailed) 
*Correlation is significant at the 0.05 level (2-tailed)
Chapter 4

Discussion

As hypothesized the residents tended to underestimate their symptoms of anxiety and depression. This tendency could potentially be due to the numerous barriers that exist and prevent older adults from seeking mental health treatment; such as the stigma associated with mental health concerns, the lack of awareness or recognition of anxiety and depressive symptoms, or fear (Harman & Reynolds, 2000; Yang & Jackson, 1998). Additional research has also highlighted the discrepancy between self-reporting symptoms and the actual prevalence of anxiety and depression in older adults in long term care facilities (Administration on Aging, 2001; Morgan et al., 2001; Wagenaar et al., 2003).

The staff and administrators judgments of the resident’s symptoms of anxiety and depression differed significantly with the PI’s judgments. This discrepancy would indicate a necessity for education, training, and communication of mental health care for the administrators and staff, in order to meet the needs and provide appropriate referrals for treatment for the residents (Chapin et al., 2004; Dobbs et al., 2006). However, in order to ensure that standardized and complete training is provided and required for all staff and administrators of ALFs action may need to be taken by the local and federal government.

The data suggest that despite the staff’s perception of mental health concerns among the residents, the ALF is deficient in offering and providing appropriate mental health services
because none of the residents were receiving mental health services, even those residents who were judged to be depressed and anxious by the majority of staff and administrators. This disparity between the perceived mental health needs of the ALF residents and the services provided by the ALF needs to be addressed in order to provide appropriate total health care to the residents.

The semi-structured interviews revealed two themes of protective factors for many residents, faith and family support. Religious beliefs and social support have been explored and examined in previous research studies, including Braam et al. (2001) which discovered that religious practices were correlated with a reduction in depressive symptoms in an older adult sample of European participants. In addition, Hays, Steffens, Flint, Bosworth, & George (2001) uncovered the importance of social support in protecting against depression, as well as the loss of basic activities of daily living that was found in older adults living with depression.

There are a few limitations with this study; only one ALF was surveyed, limiting the sample size as well as the overall ability to generalize the results to other ALF populations. The CES-D and GAD-7 are imperfect measures that do not assess and identify all the symptomology for depression and anxiety. The KSADS-PL was not originally intended for use with an older population and may not have incorporated every aspect of aging into the semi-structured interview. Also, the PI served as the rater, possibly introducing bias; another is that different measures were used by different participants.

Implications for future research and policy include further examination of how to engage ALF residents in mental health services, particularly if the administrators and staff were aware of the resident’s symptoms. Future research may need to examine the reasons why residents of
ALF tend to underestimate their symptoms of anxiety and depression. This study indicates that there are systemic changes that should occur in order to meet the mental health needs of residents in ALFs. Additional education and training should be provided to the administrators, staff, as well as the residents of ALF in order to help facilitate aging in place and appropriate mental health care. Standardized tools for screening for anxiety and depression should be provided to the staff and administrators of ALFs in order to assess for symptomology and provide the resident with resources and referrals to local mental health agencies, engaging the resident in mental health services if necessary or requested. Overall, laws and legislation will need to be passed mandating basic mental health education, training, and services for administrators and staff of ALF, in order to ensure appropriate and effective mental health care for older adults.
References


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   Ford, D. E. (2003). Primary care patients with depression are less accepting of treatment
   than those seen by mental health specialists. *Journal of General Internal Medicine, 18*,
   991-1000.

   perspective on mental health in assisted living. *Psychiatric Services, 54*(12), 1644-1646.


Zimmerman, S., Williams, C. S., Reed, P. S., Boustani, M., Preisser, J. S., Heck, E., … Sloane, P.
   D. (2005). Attitudes, stress, and satisfaction of staff who care for residents with
dementia. *The Gerontologist, 45*(1), 96-105.
Appendix A

Participant Contacts
<table>
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<tr>
<th>Facility</th>
<th>Contact Info</th>
<th>Other</th>
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<tbody>
<tr>
<td>Avamere at Sherwood</td>
<td>16500 Century Drive Sherwood OR 97140</td>
<td>Owner: Avamere Sherwood Administrator: Caren Andress</td>
</tr>
<tr>
<td></td>
<td>Ph: (503) 625-7333</td>
<td>Capacity: 65</td>
</tr>
<tr>
<td></td>
<td>Fax: (503) 625-6565</td>
<td>Accepts Medicaid</td>
</tr>
<tr>
<td>Cedar Creek Assisted Living Community</td>
<td>15677 SW Oregon Sherwood OR 97140</td>
<td>Administrator: Jim Reed</td>
</tr>
<tr>
<td><a href="http://www.cedarcreakkassistedliving.net">http://www.cedarcreakkassistedliving.net</a></td>
<td>Ph: (503) 625-9481</td>
<td>Capacity: 58</td>
</tr>
<tr>
<td></td>
<td>Fax: (503) 625-1372</td>
<td>Accepts Medicaid</td>
</tr>
<tr>
<td>Woodland Heights</td>
<td>9355 SW McDonald Street Tigard OR 97223</td>
<td>Owner: Woodland Heights LLC</td>
</tr>
<tr>
<td></td>
<td>Ph: (503) 684-9696</td>
<td>Administrator: Leah Fox Lewis</td>
</tr>
<tr>
<td></td>
<td>Fax: (503) 684-9892</td>
<td>Capacity: 64</td>
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<tr>
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<tr>
<td>Riverwood Assisted Living</td>
<td>18321 SW Pacific Highway Tualatin OR 97062</td>
<td>Owner: Mountain West Retirement Corporation</td>
</tr>
<tr>
<td></td>
<td>Ph: (503) 925-9310</td>
<td>Administrator: Nino Cristoforo</td>
</tr>
<tr>
<td></td>
<td>Fax: (503) 925-0211</td>
<td>Capacity: 74 (59 units)</td>
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<tr>
<td>Beaverton Hills Assisted Living Residence</td>
<td>4525 SW 99th Avenue Beaverton OR 97005</td>
<td>Owner: Mountain West Retirement Corporation</td>
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<tr>
<td></td>
<td>Ph: (503) 520-1350</td>
<td>Administrator: Jason Dudley</td>
</tr>
<tr>
<td></td>
<td>Fax: (503) 671-0511</td>
<td>Capacity: 75</td>
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<tr>
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<td>14570 SW Hart Road Beaverton OR 97007</td>
<td>Owner: Canfield Place, LLC</td>
</tr>
<tr>
<td><a href="http://www.leisurecare.com">http://www.leisurecare.com</a></td>
<td>Ph: (503) 626-5100</td>
<td>Administrator: William Hess</td>
</tr>
<tr>
<td></td>
<td>Fax: (503) 526-3803</td>
<td>Capacity: 100</td>
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</tr>
<tr>
<td>Farmington Square</td>
<td>14420 SW Farmington Rd. Beaverton, OR 97005</td>
<td>Administrator: Eric Williams</td>
</tr>
<tr>
<td><a href="http://www.farmingtonsquare.com">www.farmingtonsquare.com</a></td>
<td>Ph: (503) 626-2273</td>
<td>ewilliams@farmingtonsquare</td>
</tr>
<tr>
<td></td>
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<td>Capacity: 60</td>
</tr>
<tr>
<td>Edgewood Point Assisted Living</td>
<td>7733 SW Scholls Ferry Beaverton OR 97008</td>
<td>Owner: Beaverton Assisted Living</td>
</tr>
<tr>
<td><a href="http://www.edgewood-point.com">http://www.edgewood-point.com</a></td>
<td>Ph: (503) 671-9474</td>
<td>Administrator: Steve Worral</td>
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<tr>
<td></td>
<td>Fax: (503) 671-9245</td>
<td>Capacity: 59</td>
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<tr>
<td>Hearthstone at Murryhill</td>
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<td>Owner: Hearthstone at Murrayhill</td>
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<tr>
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<td>Ph: (503) 520-0911</td>
<td>Administrator: Bonnie Sloat</td>
</tr>
<tr>
<td></td>
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<tr>
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<td>Does not accept Medicaid clients</td>
</tr>
<tr>
<td>Hearthstone at Beaverton</td>
<td>12520 SW Hart Road Beaverton OR 97008</td>
<td>Owner: Hearthstone at Murrayhill</td>
</tr>
<tr>
<td><a href="http://www.hearthstonealc.com">http://www.hearthstonealc.com</a></td>
<td>Ph: (503) 641-0911</td>
<td>Administrator: Susan Magnus</td>
</tr>
<tr>
<td></td>
<td>Fax: (503) 641-1118</td>
<td>Capacity: 75</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does not accept Medicaid clients</td>
</tr>
<tr>
<td>Rosewood Park Retirement and Assisted Living Residence</td>
<td>2405 SE Century Blvd. Hillsboro OR</td>
<td>Owner: Rosewood Investors Group</td>
</tr>
<tr>
<td></td>
<td>Ph: (503) 642-2100</td>
<td>Administrator: Roberta Bradfield</td>
</tr>
<tr>
<td></td>
<td>Fax: (503) 642-1480</td>
<td>Capacity: 85</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accepts Medicaid</td>
</tr>
<tr>
<td>Facility Name</td>
<td>Address</td>
<td>Owner</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Marquis Vintage Suite of Wilsonville</td>
<td>30900 SW Parkway Ave, Wilsonville OR 97070</td>
<td>Marquis Companies</td>
</tr>
<tr>
<td>Jennings-McCall Center</td>
<td>2221 Oak Street, Forest Grove OR 97116</td>
<td>Grand Lodge of AF &amp; AM of Oregon</td>
</tr>
<tr>
<td>The Grove Assisted Living</td>
<td>2112 Oak Street, Forest Grove OR 97116</td>
<td>The Grove LLC</td>
</tr>
<tr>
<td>Regency Park Assisted Living</td>
<td>8300 SW Barnes Road, Portland OR 97225</td>
<td>Regency Park Apts Ltd Part</td>
</tr>
<tr>
<td>Raleigh Hills Assisted Living</td>
<td>4815 SW Dogwood Lane, Portland OR 97225</td>
<td>Raleigh Hills Assisted Living</td>
</tr>
<tr>
<td>Park Place Assisted Living Community</td>
<td>8445 SW Hemlock Street, Portland OR 97225</td>
<td>Park Place Assisted Living Community, LLC</td>
</tr>
<tr>
<td>Avamere at Bethany</td>
<td>Avamere Court, Portland OR 97229</td>
<td>Avamere Bethany Operations</td>
</tr>
<tr>
<td>Prestige Assisted Living at Summerplace</td>
<td>15727 NE Russell St.Portland, OR 97230</td>
<td>Prestige Care Inc., LLC</td>
</tr>
<tr>
<td>Sellwood Landing Assisted Living Community</td>
<td>8517 SE 17th Av, Portland, OR 97202</td>
<td>Sunwest Management, Inc.</td>
</tr>
</tbody>
</table>
Appendix B

Informed Consents
Informed Consent (Residents)

Title of Research: Mental Health Care
Researcher: Clarissa Gayer, MA

Explanation of Procedures
This research study is designed to examine the perceived need of mental health care in assisted living facilities. Clarissa Gayer, a graduate student at the George Fox University Graduate School of Clinical Psychology in Newberg, Oregon, is conducting this study to learn if there is a disparity between the perceived mental health needs of residents, staff, and administrators of assisted living facilities. Participants will be randomly selected to complete some demographic data, two self report measures, and semi-structured interviews, which will last for approximately one hour. The interview will be transcribed for the purpose of data analysis. The interviews will be conducted at a setting that is mutually agreeable to the participant and the researcher.

Risks and Discomforts
There are no risks or discomforts that are anticipated from your participation in the study. Potential risks or discomforts include possible emotional feelings of sadness when asked questions during the interview.

Benefits
The anticipated benefit of participation is the opportunity to discuss feelings, perceptions, and concerns related to the experience of mental health care.

Alternative Treatments
Because this study does not involve specific treatments or procedures, there are no known alternative treatments to participating in this study.

Confidentiality
The information gathered during this study will remain confidential in a locked cabinet during this project. Only the researcher and George Fox University will have access to the study data and information. There will not be any identifying names or information available to anyone. The results of the research may be published in a professional journal or presented at professional meetings. The information will help psychologists, assisted
living facilities, and others to better understand how to provide quality services for older adults. If there is any current suicidal ideation or other assessed risks, the staff of your residence or your primary care doctor may be notified for your safety and protection.

Withdrawal without Prejudice
Participation in this study is voluntary; refusal to participate will involve no penalty. Each participant is free to withdraw consent and discontinue participation in this project at any time prior to data analysis, without prejudice. Furthermore, a decision to participate or not to participate will not influence in any way the care you or your loved one receives in this assisted living facility.

Questions
Any questions concerning the research project can contact Clarissa Gayer at 248-854-4644 or CGayer05@georgefox.edu. Questions regarding rights as a person in this research project should be directed to Trevor Hall, PsyD or George Fox University Human Research Subjects Board Chairman, at 503-538-8383. For crisis or additional support please contact the US National Suicide Hotline at 1-800-784-2433. For further psychological care contact Lifeworks Northwest at 503-641-1475.

Agreement
I have read and choose to participate in this study. I have received a copy of this informed consent. Your signature below indicates that you agree to participate in this study.

__________________________________________  ______________________________
Signature of Participant                           Date

Participant’s Name (Printed)

__________________________________________  ______________________________
Signature of Researcher                           Date
Informed Consent (Administrators and Staff)

Title of Research: Mental Health Care

Researcher: Clarissa Gayer, MA

I understand that this research study is designed to examine the perceived need of mental health care in assisted living facilities. Clarissa Gayer, a graduate student at the George Fox University graduate school of clinical psychology in Newberg, Oregon; is conducting this study to learn if there is a disparity between the perceived mental health needs of residents, staff, and administrators of assisted living facilities. Participation in the study involves completion of a short demographic data, a semi-structured interview, and determining whether the participating residents exhibit symptoms of anxiety or depression, which will last for approximately ten minutes. The interview will be transcribed for the purpose of data analysis. The interviews will be conducted at a setting that is mutually agreeable to the participant and the researcher.

I also understand that participation in this study is voluntary; refusal to participate will involve no penalty. Each participant is free to withdraw consent and discontinue participation in this project at any time, prior to data analysis, without prejudice from this institution. Furthermore, there are no anticipated risks or discomforts in participation in the study. The anticipated benefit in participation in the study is the opportunity to gain a better understanding of the need for mental health care in older adults. Due to the fact that this study does not involve specific treatments or procedures, there are no known alternative treatments to participating in this study.

I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to self or to another person; the clinician is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that an older adult is being sexually or physically abused or is at risk of such abuse; the clinician is legally required to take steps to protect the older adult, and to inform the proper authorities.

C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

D. There will not be any identifying names or information available to anyone. The results of the research may be published in a professional journal or presented at professional meetings.

If I have any questions regarding this consent form or about this study I can contact Clarissa Gayer at 248-854-4644 or CGayer05@georgefox.edu.

I have read and understand the above. I consent to participate in the evaluation and interview of this study. I understand that I may stop at any time without prejudice or penalty.

Signature of Participant

Date

Participant’s Name (Printed)

Signature of Researcher

Date
Appendix C

Semi-structured Interview of Administrators
**Semi-structured Interview (Administrators)**

**Demographics**
Age:
Gender:
Ethnicity:
Level of Education:
Length of employment at this facility:
Length of employment as an administrator of an Assisted Living Facility:

1. Are there mental health services offered at this facility?
   - Yes
   - No
   a. If so do residents utilize these services?
      - Yes
      - No
2. Is there mandatory training for all direct care staff?
   - Yes
   - No
   a. If so does this training include mental health information?
      - Yes
      - No
   b. Are staff retrained or trained when techniques are available?
      - Yes
      - No
   c. Have you received any mental health training?
      - Yes
      - No
3. On a scale of 1 to 5: How well do you know (resident)?
   
   1  2  3  4  5
   Not at all  A little  Some what  Well  Very well

4. Do you believe (resident) displays any symptoms of anxiety?
   - Yes
   - No
   I don’t have enough training to determine

5. Do you believe (resident) displays any symptoms of depression?
   - Yes
   - No
   I don’t have enough training to determine

6. Which of the following are symptoms of anxiety?
   Chronic worry, nervousness, tension, feelings of dread, panic, fearful, irritability, restlessness, feelings of being on edge, sleep disturbances, pacing, wandering, muscle tension, concentration problems, fidgety, tires easily, headaches, chest pains, stomach complaints, nausea, pain, sweating, trembling, dizziness, shortness of breath, these symptoms impair the residents functioning.

7. Which of the following are symptoms of depression?
   Feeling sad, empty, tearful, social withdrawal, lack of interest in once enjoyed activities, despair, loneliness, helplessness, hopelessness, guilt, concentration problems, sleep disturbances, fatigue, restless, agitated, changes in appetite and/or weight, suicidality, cognitive changes.
Appendix D

Semi-structured Interview of Direct Care Staff
Semi-structured Interview (Staff)

Demographics
Age:
Gender:
Ethnicity:
Level of Education:
Length of employment at this facility:
Length of employment as an administrator of an Assisted Living Facility:

1. Are there mental health services are offered at this facility?
   Yes  No
   a. If so do residents utilize these services?
      Yes  No

2. Is there mandatory training for all direct care staff?
   Yes  No
   b. If so does this training include mental health information?
      Yes  No
   c. Are staff retrained or trained when techniques are available?
      Yes  No
   d. Have you received any mental health training?
      Yes  No

3. On a scale of 1 to 5: How well do you know (resident)?
   1  2  3  4  5
   Not at all  A little  Some what  Well  Very well

4. Do you believe (resident) displays any symptoms of anxiety?
   Yes  No  I don’t have enough training to determine

5. Do you believe (resident) displays any symptoms of depression?
   Yes  No  I don’t have enough training to determine

6. Which of the following are symptoms of anxiety?
   Chronic worry, nervousness, tension, feelings of dread, panic, fearful, irritability, restlessness, feelings of being on edge, sleep disturbances, pacing, wandering, muscle tension, concentration problems, fidgety, tires easily, headaches, chest pains, stomach complaints, nausea, pain, sweating, trembling, dizziness, shortness of breath, these symptoms impair the residents functioning.

7. Which of the following are symptoms of depression?
   Feeling sad, empty, tearful, social withdrawal, lack of interest in once enjoyed activities, despair, loneliness, helplessness, hopelessness, guilt, concentration problems, sleep disturbances, fatigue, restless, agitated, changes in appetite and/or weight, suicidality, cognitive
Appendix E

Semi-structured Additional Interview (Residents)
Semi-structured Additional Interview (Residents)

Demographics
Age:
Gender:
Ethnicity:
Veteran Status:
Marital Status:

1. How long have you been living or staying here in this building?
2. Would you like someone to visit with you?
3. Symptoms
   a. Trouble sleeping
      i. Falling asleep
      ii. Staying asleep?
   b. Changes in appetite/weight
   c. Lack of interest in once enjoyed activities
   d. Stay in room, don’t participate in offered activities (Social Isolation)
      i. What do you enjoy doing?
      ii. “Don’t care anymore”
   e. Alcohol consumption
   f. Depressed
      i. “down”
      ii. “in the dumps”
      iii. “blue”
      iv. “heartbroken”
   g. Anxiety
      i. worry
      ii. “nerves”
      iii. Somatic
   h. Mania
      i. Hallucinations
      ii. Delusions
   i. Suicidal ideation/plans/attempts
   j. ADL’s
   k. Memory Problems

4. Medical Conditions:
5. Current Medications:
6. Assess Loss
7. Other Symptoms:
8. Do you utilize any services offered here at this ALF?
9. Would you like any other services offered here?
Appendix F

Center for Epidemiological Studies Depression Scale (CES-D)
Center for Epidemiological Studies Depression Scale (CES-D)

Instructions: I am going to read a list of ways you may have felt. Please tell me how often you have felt this way during the past week: rarely or none of the time; some or a little of the time; occasionally or a moderate amount of time; or most or all of the time.

<table>
<thead>
<tr>
<th>During the past week that would be from ___ through today:</th>
<th>Rarely or none of the time (less than 1 day)</th>
<th>Some or a little of the time (1-2 days)</th>
<th>Occasion-ally or a Moderate Amount of Time (3-4 days)</th>
<th>Most or all of the time (5-7 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You were bothered by things that usually don't bother you.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. You did not feel like eating; your appetite was poor.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. You felt that you could not shake off the blues even with help from your family or friends.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. You felt that you were just as good as other people.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5. You had trouble keeping your mind on what you were doing.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. You felt depressed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. You felt that everything you did was an effort.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. You felt hopeful about the future.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9. You thought your life had been a failure.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. You felt fearful.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Your sleep was restless.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. You were happy.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13. You talked less than usual.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. You felt lonely.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. People were unfriendly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. You enjoyed life.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>17. You had crying spells.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. You felt sad.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. You felt that people disliked you.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. You could not get &quot;going.&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

To total: Add all circled numbers in each column

Total:
Appendix G

The Generalize Anxiety Disorder Screener (GAD-7)
The Generalize Anxiety Disorder Scale (GAD-7)

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>Not at all sure</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it's hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Add the score for each column

Total Score (add your column scores)  

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ___
Somewhat difficult ___
Very difficult ___
Extremely difficult ___
Appendix H

Curriculum Vita
Clarissa N. Gayer
9920 SW Conestoga Dr. Apt #201
Beaverton, OR 97008
(248) 854-4644
CGayer05@georgefox.edu

Educational History

2005- Present  
Student in Doctorate of Clinical Psychology Program  
Graduate Department of Clinical Psychology, APA Accredited  
George Fox University, Newberg, Oregon  
Anticipated graduation 2010

November 2007  
Masters of Arts in Clinical Psychology  
Graduate Department of Clinical Psychology, APA Accredited  
George Fox University, Newberg OR

2002- May 2003, 2004  
Bachelor of Arts in Psychology (Clinical Track)  
Minor: Christian Thought  
William Tyndale College, Farmington Hills, MI

Supervised Clinical Experience

2008- Present  
Pre-Internship  
LifeWorks Northwest, Legacy Clinic, Tigard, Oregon  
Facility: Medical Outpatient and Community Mental Health  
Population: Older Adults and Adults  
Supervisors: Mary Kay August, PhD, Sarah Hopkins, PsyD, and Patricia Warford, PsyD  
Clinical Duties:  
- Consult with a multidisciplinary team of primary care physicians, psychiatrists, nurses, social workers, and primary care providers  
- Provide recommendations to physicians regarding pharmacological, psychological, and other interventions  
- Complete IMPACT, evidenced-based depression care training  
- Conduct diagnostic clinical interviews  
- Assess cognitive functioning, neuropsychological deficits, and personality disorders  
- Determine differential diagnoses of dementia and depression  
- Write integrated psychological reports, develop treatment plans, and maintain progress notes  
- Provide on-call crisis interventions for medical patients with psychiatric emergencies
Mental Health Care

- Conduct brief and long-term individual therapy
- Provide family therapy with primary care providers
- Develop and lead two caregiver support groups
- Conduct Resident Reviews, Intakes, and Level II PASSR Comprehensive Evaluations
- Receive one hour of individual supervision per week
- Supervise therapy conducted by one second-year PsyD student and one first-year PsyD student, one hour per week
- Present two case presentations to a clinical team

2007-2008

**Practicum II**

*LifeWorks Northwest, Millikan Site, Beaverton, Oregon*

Facility: Community Mental Health and Day Treatment Program

Population: Older Adults

Supervisors: Mary Kay August, PhD, Mark McMinn, PhD, and Robert Buckler, PhD

Clinical Duties:

- Provided brief individual therapy, milieu therapy, and case management for older adult clients
- Provided group therapy for both day treatment programs; dementia patients and those with mental health concerns
- Conducted family therapy with primary care providers
- Performed neuropsychological and cognitive/intellectual assessments
- Determined differential diagnoses of dementia and depression
- Provided recommendations to physicians regarding pharmacological, psychological, and other interventions
- Received weekly individual and group supervision
- Made two case presentations to a clinical team

2006-2007

**Practicum I**

*Columbia River Mental Health, Vancouver, Washington*

Facility: Community Mental Health

Population: Adults, Older Adults, and Adolescents

Supervisors: Doug Park, PhD, Clark Campbell., PhD, ABPP, and Scott Koeneman, MA

Clinical Duties:

- Conducted individual therapy with clients diagnosed with personality disorders, mood disorders, anxiety disorders, schizophrenia, PTSD, ADHD, and alcohol and drug abuse
- Administered the PHQ-9 with appropriate clientele
- Used empirically supported treatment of depression and monitored symptoms
• Developed and implemented two positive psychology and recovery groups
• Consulted with mental health staff
• Provided 50-minute individual psychotherapy sessions, with each client on a weekly basis
• Maintained progress notes following each session
• Received weekly individual and group supervision
• Made two case presentations to a clinical team

2005- 2006

Prepracticum
George Fox University, Newberg, Oregon
Facility: Outpatient Treatment
Population: Young Adults
Supervisors: Clark Campbell, PhD, ABPP, Laura Zorich, PsyD, Ryan Hosley, MA, and Sarah Sherrard, MA
Clinical Duties:
• Provided weekly client centered psychotherapy for two undergraduate students
• Conducted intake interviews and mental status exams
• Attended weekly group and individual supervision with videotape review
• Conducted one session of therapy per week, for 10 weeks
• Obtained informed consent at the beginning of the treatment period and termination summary at the end of this period
• Clinical interviews and mental status exams
• Developed treatment plans according to clients’ personal goals
• Maintained progress notes following each session
• Made two case presentations to a clinical team

Relevant Work Experience

2007- Current
Graduate Assistant
George Fox University, Newberg, Oregon
Supervisor: Robert Buckler, PhD
• Taught several classes in Biological Basis of Behavior and Forensic Psychology in Dr. Buckler’s absence
• Researched acute intermittent prophyria and history of prescription privileges

Summer 2006
Direct Care Provider
Alterra Alzheimer’s and Memory Care Facility, Beaverton, Oregon
Supervisor: Heather Ashby
• Assessed and treated psychosocial needs of 65 residents affected with Alzheimer's disease and other dementias
Managed five night shift employees
Administered and ordered medication for all residents, while in communication with the patient’s doctors for pain management and other health concerns
Managed and maintained a safe environment for all residents with memory and physical impairments

Summer 2005
**Psychiatric Care Specialist**
Havenwyck Inpatient Psychiatric Hospital, Auburn Hills, Michigan
Supervisor: Yvonne R. Stump, L.P.N., R.N.
- Worked one on one with children, adolescents, and some adults with various psychological and behavioral problems
- Conducted didactic, therapeutic, and life skills groups daily with patients
- Charted daily on status of patients, recording behaviors, attitudes, and progress in the program
- Assessed and managed risk from self harm, and suicidal and homicidal ideation

Summer 2004
**Direct Care Provider**
Alterra Wynwood Assisted Living Care Facility, Troy, Michigan
Supervisor: Rochelle Masterson
- Cared for 80 residents while encouraging them to be independent
- Distributed medication and fed, clothed, cleaned, and assisted each resident with their daily needs
- Charted residents’ moods, behaviors, and activities every shift

**Relevant Volunteer Experience**

2008-Present
**Animal-Assisted Interactions/Therapy (Pet Partners)**
Delta Society and Oregon Humane Society, Portland, Oregon
Supervisor: Lori Kirby, Animal Behavior Specialist and Delta Society Evaluator at the Oregon Humane Society
- Animal-assisted interactions or therapy is a goal-directed intervention in which an animal is an integral part of the treatment process; and provides an educational interaction with psychological, cognitive, physical, and social benefits
- Provided animal-assisted therapy with Older Adult Day Treatment Program at LifeWorks Northwest and weekly at Maryville Nursing Home

2008-Present
**Psychodynamic Case Conceptualization Group**
Supervisor: Kirk Free, PhD
• Discussed psychodynamic theoretical orientation, case conceptualization, and treatment modalities with a group of 10 graduate students once a month, throughout the school year
• Presented psychological evaluations and conceptualized the client from a psychodynamic, object relations, and interpersonal framework

2008
**Guest Lecturer**
George Fox University, Newberg, Oregon
• Presented psychological and physical aspects of aging to undergraduate students in the Human Development class
• Answered questions and provided resources for mental health care of older adults in the surrounding community

2006-2008
**Mentor**
George Fox University, Newberg, Oregon
• Provided support, encouragement, guidance, and housing to first year and second year students
• Interviewed student candidates applying to George Fox University

2006
**Assisted in Legal Assessment and Evaluation**
George Fox University, Newberg, Oregon
Supervisor: Patricia Warford, PsyD
• Aided in the psychological assessment and evaluation of a defendant in a domestic violence court case
• Assisted in collecting an in-depth history, evaluated circumstances surrounding the charges, and administered the WAIS-III
• Researched coercion and the effects of domestic violence to inform the court’s ruling in the case
• As a result of the assessment and evaluation findings, the defendant’s charges were reduced

2003-2005
**Crisis Counselor**
Common Ground Sanctuary Crisis Line, Bloomfield Hills, Michigan
Supervisor: Lisa Turbeville, MSW
• Implemented a crisis intervention model to counsel a broad spectrum of callers including community mental health patients in crisis, four hours a week
• Assessed callers for suicidal and homicidal ideation and made the appropriate referrals; when necessary, called local police
• Provided callers with resources for emergency domestic violence shelters, legal aid, and free psychological services
2003- 2004  
**Mentor**
*Vista Maria*, Dearborn Heights, Michigan  
Supervisor: Wendy Kearney, MSW  
- Provided support, encouragement, and guidance to adolescent girls in the residential treatment program

2003- 2005  
**Advocate**
*Joseph J. Laurencelle Memorial Foundation (JJLMF)*, Beverly Hills, Michigan  
Supervisor: Michael Cummings, Program Director  
- Created awareness of the stigma associated with mental illness at local high schools through educational presentations

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**Membership in Professional Associations**

2007-Present  
APA Division 12, Section 2, Clinical Geropsychology  
2007-Present  
Professionals of Long Term Care (PLTC) Student Member  
2005-2007  
President of Multicultural/Diversity Group, George Fox University  
2005- Present  
Member of Multicultural/Diversity Group, George Fox University  
2004- Present  
American Psychological Association Graduate Student Affiliate

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**Research Experience**

2007  
**Research Assistant**  
George Fox University, Newberg, Oregon  
- Completed data collection for doctoral dissertation  
- Administered WRAT-4 and WRAML-2 to high school participants

2005 – Present  
**Dissertation and Research Vertical Team**  
George Fox University, Newberg, Oregon  
*Supervisors*: Trevor Hall, PsyD, Kathleen Gathercoal, PhD, and Sarah Hopkins, PsyD
  
- Participate in bi-weekly meetings with a research vertical team for consultation regarding dissertation progress and research design  
- Completing doctoral dissertation titled *Perceived Need of Mental Health Care Identified by Residents, Administrators, and Direct Care Staff of an Assisted Living Facility*  
- Investigate the disparity between the perceived needs of mental health care of residents in an assisted living facility and the direct care staff and administrators  
- Administered CES-D, GAD-7, and K-SADS semi-structured interview with modifications to residents at an assisted living facility
- Conducted semi-structured interviews with direct care staff and administrators of the same assisted living facility to identify any discrepancies in perceived needs of mental health care
- Provided training to assisted living facility in order to educate staff in mental health concerns and care options

2004

**Undergraduate Thesis**
William Tyndale College

*Supervisor:* Professor Randall, PhD

- Completed undergraduate thesis titled *Misperceptions of Mental Illness: In Spite of Education in Mental Health Awareness*
- Administered surveys to random participants and then provided each with educational material on stigma and mental illness
- Research supported the hypothesis that the more education one has regarding mental illness, then the probability of one being prejudiced towards someone with mental illness decreases
- Implications of this study revealed additional education and awareness of mental illness is needed in society to erase stigma

**Professional Conferences and Seminars**

**October 2008**  
*Suicide Prevention in Older Adults: 2nd Annual Forum*  
Metropolitan Family Service, Cascadia Behavioral Health, and Aging & Disability Services, Portland, Oregon

**October 2008**  
*IMPACT: Evidence-Based Depression Care*  
Online training from the University of Washington, Department of Psychiatry and Behavioral Sciences

**October 2008**  
*Multicultural Competencies*  
Keynote Speaker: Julie Oyemaja, PsyD  
LifeWorks Northwest, Beaverton, Oregon

**September 2008**  
*National Register and Licensure*  
Keynote Speaker: Judy Hall, PhD  
George Fox University, Newberg, Oregon

**June 2008**  
*2008 Annual Northwest Assessment Conference*  
*WAIS-IV and WMS-IV: An Overview, Assessment, and Intervention of ADHD in Children, Teens, and Adults*  
Keynote Speakers: Bruce A. Bracken, PhD & Larry Weiss, PhD  
George Fox University, Newberg, Oregon
<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
<th>Keynote Speaker(s)</th>
<th>Institution</th>
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<tbody>
<tr>
<td>February 2008</td>
<td>The Psychology of Forgiveness in Clinical Practice: The Benefits and Pitfalls of Helping Clients Forgive</td>
<td>Nathaniel G. Wade, PhD</td>
<td>George Fox University, Newberg, Oregon</td>
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<tr>
<td>January 2008</td>
<td>Case Presentation and Integration Issues</td>
<td>William Buhrow, PsyD</td>
<td>George Fox University, Newberg, Oregon</td>
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<td>November 2007</td>
<td>Assessing Competence to Stand Trial in Oregon and Risk Assessment at Oregon State Hospital</td>
<td>Dan Smith, PsyD and Elena Balduzzi, PhD</td>
<td>George Fox University, Newberg, Oregon</td>
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<tr>
<td>September 2007</td>
<td>Forensic Case Presentation</td>
<td>Laura Zorich, PsyD</td>
<td>George Fox University, Newberg, Oregon</td>
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<td>September 2007</td>
<td>Psychodynamic Diagnostic Manual (PDM)</td>
<td>Nancy McWilliams, PhD</td>
<td>Oregon Health and Science University, Portland, Oregon</td>
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<td>January 2007</td>
<td>National Multicultural Conference and Summit: The Psychology of Multiple Identities</td>
<td>Dr. Rosie Phillips Bingham, Dr. Eduardo Duran, Dr. Beverly Greene, and Dr. Melba Vasquez</td>
<td>Seattle, Washington</td>
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<tr>
<td>October 2006</td>
<td>Motivational Interviewing</td>
<td>William Miller, PhD</td>
<td>George Fox University, Newberg, Oregon</td>
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<tr>
<td>April 2006</td>
<td>Grief Issues in Psychotherapy</td>
<td>Beth Brokaw, PhD</td>
<td>George Fox University, Newberg, Oregon</td>
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<tr>
<td>March 2006</td>
<td>Recognizing and Treating Sexual Addiction in Everyday Practice</td>
<td>Earl Wilson, PhD and Ryan Hosley, MA</td>
<td>George Fox University, Newberg, Oregon</td>
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</tbody>
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November 2005  
*Relational Cognitive Therapy*  
Speaker: Mark McMinn, PhD, ABPP  
George Fox University, Newberg, Oregon

October 2005  
*The Effects of PTSD*  
Speaker: Patrick Stone, PhD  
George Fox University, Newberg, Oregon

**Grants and Scholarships Received**

- 2007  
  Multicultural and Diversity Scholarship from George Fox University  
- 2007  
  National Multicultural Conference and Summit Registration Grant

**Publications and Presentations**

Gayer, C., Hall, T., Gathercoal, K., & Hopkins, S. (March, 2009). Perceived need of mental health care identified by residents, administrators, and direct care staff of an assisted living facility. Poster presented to the annual meeting of the American Association for Geriatric Psychiatry, Honolulu, Hawai‘i.
