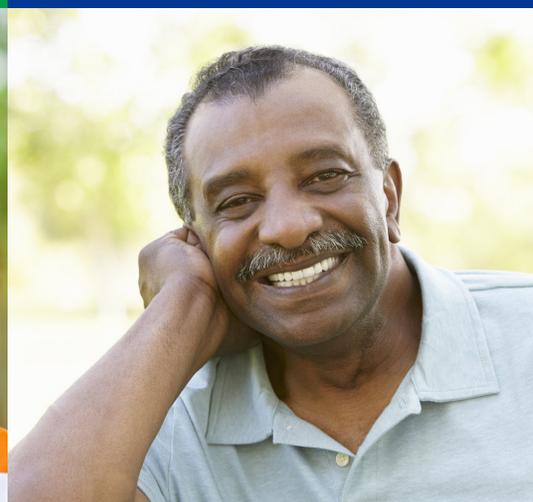


NorthWest Senior and Disability Services HOPE Senior Peer Mentoring Program

Volunteer Resource Book



August 2015

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About Your Training Handbook

Welcome to Healthy Opportunities for Personal Empowerment (HOPE). This training handbook is designed to provide knowledge and skills to assist you in mentoring older adults and people living with disabilities. This handbook also provides strategies to support individuals experiencing some of the more serious life challenges that can impact older adults and people living with disabilities. These include healthy aging, loneliness, grief and loss, anxiety, depression, caregiving, care-receiving, and suicide.

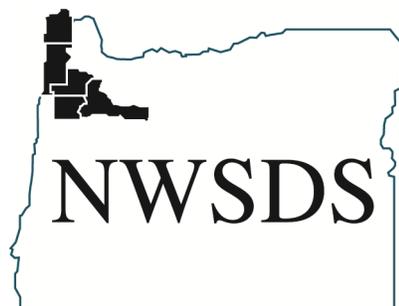
Training as a peer mentor gives you the opportunity to impact the lives of others through your own knowledge, skills, and personal life experiences. You may notice that as you interact with this material, you may discover some opportunities for personal growth. Research indicates that “peer support is a critical and effective strategy for ongoing health care and sustained behavior change for people with chronic diseases and other conditions...”¹ Throughout the training, peer mentors will gain more confidence, skills, and knowledge to share with others who may be experiencing similar life challenges. Knowledge is good; self-knowledge is better!

Your feedback on this training handbook is most welcome. Please direct your comments to NorthWest Senior & Disability Services, Attn: Senior Peer Mentoring Program, 3410 Cherry Avenue NE, Salem, OR 97303.

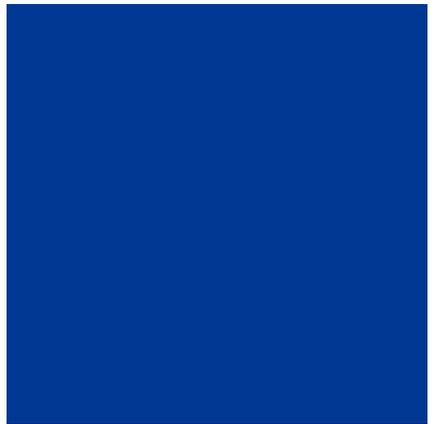
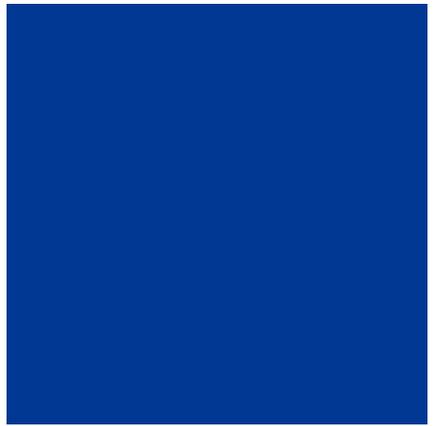
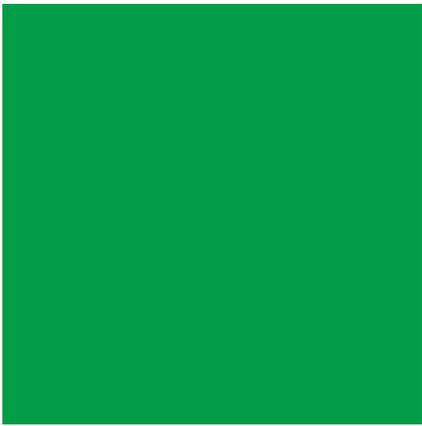
Disclaimer

The content of this training handbook is informational and, therefore, not intended to be a substitute for professional counseling and/or medical care, or other professional treatment of any kind.

This manual is a compilation of many contributors, quite a few of which are sources from articles and web-based publications. If a source is inadvertently not cited or incorrectly cited, please let NWSDS know immediately. We will make every effort to correctly cite all sources.



Section 1: Healthy Aging



Section 1: Healthy Aging

What is Healthy Aging?

We are all involved in the aging process and none can escape it. When one is young, aging is associated with growth, maturation, and discovery. Many human abilities peak before age 30, while other abilities continue to grow through life. The great majority of those over age 65 today are healthy, happy, and fully independent. However, some individuals begin to experience changes that are perceived as signs of deterioration or decline. We must try to forget the stereotypes and look at older people as unique individuals, each with a particular set of resources and challenges. The changes older people experience are not necessarily harmful.

Healthy Aging

“By 2050, there will be more than 80 million Americans over the age of 65.”² In Oregon, the projections indicate that older adults will make up more than 25% of the population by 2050. While we recognize that the population of aging Americans is growing, one of the important concepts of our philosophy is healthy aging. We define it as adding life to years rather than adding years to life. Healthy aging shifts the person’s focus to their quality of living.

“Older adults who remain active in their communities through volunteerism and workforce initiatives, live longer lives, have better cognitive health, are less likely to suffer from depression, and experience better mental and physical well-being than older adults who are not involved in their communities.”³ Research also indicates that social interaction is an essential part of healthy aging.

Although older Americans are assets to our communities and to our economy, many also require services and supports to maintain their independence. In addition to things such as proper nutrition and adequate medical care, the availability of adequate housing and transportation impact a person’s health. Some pertinent statistics regarding the services and supports older adults may need are listed below:

- One in three older adults age 65+ in Oregon will fall each year. Preventing these falls can result in improved health for older Americans. Of these falls, 20 to 30 percent will result in bruises, hip fractures, or head trauma, limiting the person’s ability to live independently.⁴
- In 2013 in Oregon, \$219 million was spent on hospitalizations due to falls.⁵
- Nationally, more than 75 percent (approximately \$1 trillion dollars) of health care costs are spent on managing chronic conditions each year.⁶
- With only 53.9 percent of Oregonians over age 65 receiving the flu vaccine in 2013, Oregon ranked 43rd out of 50 states.⁷
- In Oregon, 41 percent of Medicaid recipients with a diagnosis of Alzheimer’s disease or related dementias receive care in nursing homes compared to 6 percent of Medicaid recipients without that diagnosis.⁸

- Although some counties such as Lake, Lincoln, and Jefferson do not have public transportation systems, 5.3 million rides were given to rural area residents with the help of non-profit providers in 2010.⁹
- Oregon suffers from a shortage of practicing geriatricians. As of 2011, there were only 80 certified geriatricians in the state, leaving an estimated shortage of 149.^{10, 11}
- Oregon ranks in the top 5 among states with the highest hunger rates for residents between the ages of 50-59.”¹²

Chronic diseases among older Oregon adults, by age group, 2013¹³

Chronic Conditions	55-64 years old	65-74 years old	75-84 years old	85+ years old
Arthritis	38%	52%	56%	52%
Asthma	7%	10%	8%	8%
Cancer	13%	21%	26%	31%
Heart Attack	5%	9%	16%	13%
Heart Disease	6%	10%	14%	12%
Stroke	4%	8%	11%	15%
Diabetes	15%	18%	19%	19%
Depression	30%	21%	14%	11%
Chronic Obstructive Pulmonary Disease (COPD)	9%	13%	14%	11%
One or more chronic diseases*	66%	77%	84%	81%
High Blood	44%	55%	66%	68%
High Blood Cholesterol	46%	57%	52%	47%

**One or more chronic diseases included angina, arthritis, asthma, cancer, COPD, depression, diabetes, heart attack, or stroke.*

Blueprint for Healthy Aging

If you want to live a long, healthy life, think about the traits that healthy agers practice:

- Be self-reliant
- Practice gratitude
- Let go of regrets
- Learn to forgive
- Create healthy boundaries
- Commit to lifelong learning
- Seek to be resilient
- Choose to be happy



There will be opportunities for you to teach many new skills and strategies to your mentees as you embrace and reach out to them. For instance, you will likely have the opportunity to mention some of the specific conventional wisdoms of getting older and share about some of the specific ways to successfully age. As you assist mentees in reducing depression, overcoming anxieties, or reinforcing their own beliefs you may have the opening to share about some of the specific ways to practice healthy aging. Recall that healing is changing personal attitudes to adjust to new situations.

Conventional Wisdoms of Getting Older

Older adults have gained a lot of wisdom through experience. For many older adults, natural life-anchors are no longer available or do not work. There are many unforeseen challenges to living longer such as changes to one's finances; physical, mental, or emotional health; or social or spiritual lives.

Bear in mind that the major mental health challenges for older adults remain depression, delirium, and dementia. People are living longer than they expected and the dying process is taking longer.

Conventional Wisdoms of Living with Chronic Illness and/or Disability

Many older adults and people living with chronic illness or disability experience:

- A greater incidence of emotional distress than those who are able-bodied
- Periods of health and emotional ups and downs
- A daily reminder of mortality
- Family members who are also affected by the illness, not just the older adult

Eight Fears of Chronic Illness and/or Disability

Recognizing some of the fears associated with the experience of chronic illness and/or disability can help protect a person from further distress. Awareness can also give us insight into the world of a person living with chronic illness and/or disability. The following are the eight fears and some examples of ways to alleviate those fears:

1. The fear of loss of control
 - Separate immediate challenges from longer-term challenges
 - Make personal decisions whenever possible
 - Evaluate and change what is changeable
 - Find a true confidant
2. The fear of loss of self-image
 - List and grieve losses
 - Let go of “stuff” that is no longer important or relevant
 - Forge a new identity
 - Seek support for change
3. The fear of dependency
 - Set reasonable and reachable independence goals
 - Give to others
 - Become involved in medical decisions
 - Learn to ask for support
4. The fear of stigma
 - Reveal secret feelings to a confidant
 - Look at the world realistically
5. The fear of abandonment
 - Discuss your fears with family members who care
 - Confront your fears before trying to conquer them
 - Be sensitive to your family’s needs
6. The fear of expressing anger
 - Evaluate yourself
 - Expect anger to well up from within yourself
7. The fear of isolation
 - Prepare yourself for others’ ignorance and discomfort
 - Prepare a statement to say when you feel rejected or ignored
 - Let people know how much support you need and/or want
8. The fear of death
 - Desensitize yourself to death
 - Take charge of your fear by taking control of your life

Coping Strategies for Illness or Disability

This is the process of managing taxing circumstances, expending personal effort to respond to challenges, and seeking to master, minimize, reduce, or tolerate stress or conflict. Suggestions for accepting your illness or disability and liking yourself for who you are, include:

- Living in the present—This allows a person to take on the habit of “daily-ness” which contributes to finding pleasure in the moment; but not ignoring the future.
- Not defining yourself or personhood by the chronic illness or disability.
- Taking charge of your day—Practice the self-management of your wellness.
- Managing symptoms—Work with your physician, keep a journal, organize medications, and keep a calendar of appointments.
- Managing energy—Be cautious not to bankrupt your energy.
- Managing emotions—Be alert for depression and seek treatment including support groups.
- Managing wellness—Plan good nutrition, stay as active as possible, manage stress, and engage in positive relationships.
- Allowing yourself to grieve what you have lost.
- Naming and facing your worst fears can create a psychological magic—What had been hidden and unspeakable is now acknowledged and engaged.
- Learning to value your own company and becoming your own best friend—Find your self-worth based on inner strength rather than what you can do.
- Allowing yourself to express your feelings and fears.
- Exploring the availability of adaptive tools and devices.



“
There are only four kinds of people in the world:
Those who have been caregivers.
Those who are currently caregivers.
Those who will be caregivers.
And, those who will need caregivers.”

—Rosalynn Carter

Caregiving and Care-Receiving

Top 10 Things You Really Need to Know to be a Successful Caregiver

1. “Choose to take charge of your life, and don't let your loved one's illness or disability always take center stage.
2. Remember to be good to yourself. Love, honor and value yourself. You're doing a very hard job and you deserve some quality time just for you.
3. Watch for signs of depression and don't delay in getting professional help when you need it.
4. When people offer to help, accept the offer and suggest specific things they can do.
5. Educate yourself about your loved one's condition. Information is empowering.
6. There's a difference between caring and doing. Be open to new technologies and ideas that promote your loved one's independence and help you do your job easier.
7. Trust your instincts. Most of the time they'll lead you in the right direction.
8. Grieve for your losses, then allow yourself to dream new dreams.
9. Stand up for your rights as a caregiver and as a citizen.
10. Seek support from other caregivers. There is great strength in knowing that you are not alone.”¹⁴

Signs of Caregiver Burnout

Caregiving can be taxing. If you or someone you know is a caregiver, be aware of these signs of caregiver burnout. If you see the following signs, share the successful caregiver guidelines (above) with them.

- Withdrawal from friends, family, and other natural support
- Changes in appetite, weight, or both
- Feeling blue, irritable, hopeless, and helpless
- Loss of interest in activities
- Changes in sleep patterns
- Emotional and physical exhaustion
- Getting sick more often

Section 2:

Mental Health First Aid USA



Section 2: Mental Health First Aid USA

What is Mental Health First Aid USA?

Mental Health First Aid (MHFA) is an integral component of the basic training curriculum for Senior Peer Mentors. It is a nationally-recognized, eight-hour, interactive course designed to teach individuals how to support someone who is developing a mental health problem or experiencing a mental health crisis.

In the fall of 2014, the HOPE Program was authorized to use MHFA as an integral part of our curriculum with the stipulation we maintain fidelity to Mental Health First Aid USA instructor and course expectations. Mental Health First Aid USA has proven to be effective in peer-reviewed studies; it is listed as an evidence-based program and practice.

What You Will Learn in MHFA

- Suicidal behavior
- Depressive symptoms
- Non-suicidal self-injury
- Panic attacks
- Traumatic events
- Anxiety symptoms
- Understanding when psychosis may occur

The Five-Step Action Plan (ALGEE):

- A-Assess for risk of suicide or harm
- L-Listen nonjudgmentally
- G-Give reassurance and information
- E-Encourage appropriate professional help
- E-Encourage self-help and other support strategies

The eight-hour interactive course is a required component for certification as a HOPE Senior Peer Mentor. During your orientation, you will be given dates or locations for all of the training courses. There is no cost for this special training. You will receive separate MHFA certification.

Testimonials of Mental Health First Aid Trainees

“MHFA training was excellent. We were given tools to use to determine when an individual is having a mental health crisis as well as tools to use to keep them safe while waiting for professional assistance. I was especially impressed that an emphasis was placed on listening attentively and reflectively to the individual in crisis.”

— Nancy

“We have all been trained for years for physical first aid, it just makes sense to be trained for mental health first aid. I learned no matter what the mental health issue, people can heal. It was neat to attend class with folks who had experienced mental health issues, it was safe enough for them to openly share. Everyone learned.”

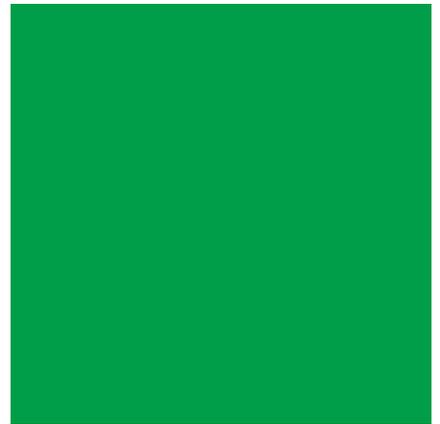
— Beth

“The course, Mental Health First Aid, provides concrete information, resources, and appropriate responses. I feel better prepared when meeting mentees with mental health issues.”

— Jane

Section 3:

Communication and Engagement Strategies



Section 3: Communication and Engagement Strategies

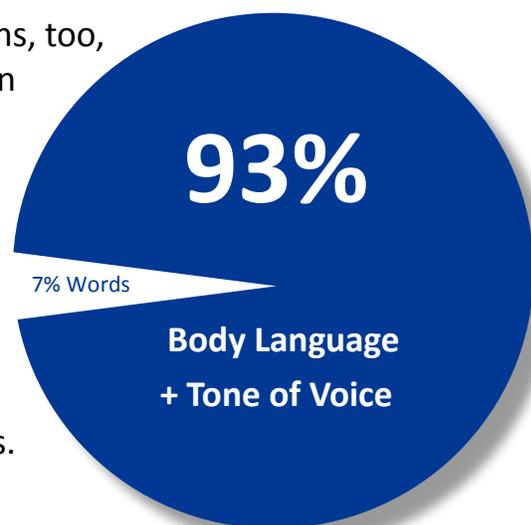
Basic Communication Skills—A Refresher

As a mentor, clear, concise, and effective communication will positively impact the relationship with the mentee. Communication involves two elements both verbal and nonverbal. When we communicate with someone we not only transmit a message; we transmit meaning. Also, communication is often very different among various cultures.

All communication is important. Every message has a content and a relationship component. Content is what is said (verbal) and relationship is how it is said (nonverbal).

Both verbal and nonverbal language matter. More than 93% of messages are communicated by body language and tone of voice. If there is conflict between a verbal and a nonverbal message, the nonverbal message is what is communicated. Words shape our thoughts or perceptions, too, so what we call something matters. For example: “A person living with dementia,” is not a “demented person.” Think about your choice of words and nonverbal cues as you work with your mentee. It is important because words:

- have the power to create and label experience.
- can make and break relationships.
- must relate to the context of the communication.
- can reflect bias toward cultures that can create barriers.



Active Listening

Active Listening involves reflecting back the feelings and the situation that you believe the other person is experiencing, to check that you have understood them correctly. For example, a mentor could say, “So what I hear you saying is that you are feeling overwhelmed and sad about the changes that are occurring in your life,” after listening to a mentee tell about their symptoms of depression.

“Active listening goes beyond merely hearing the other person. Active listening means being attentive to what someone else is saying. The goal of active listening is to understand the feelings and views of the person.”¹⁵ For example, a mentor could say, “It sounds like you are really having a difficult time handling the loss of your spouse,” to comfort someone who is recently widowed.

Body Language

Our body communicates both intentionally and unintentionally. It is important to be mindful of the cultural differences around body language. A few types of body language include eye contact, facial expressions, posture, gestures, etc. All body language will have an impact on how your message is received. “Be conscious of your own body language, as perception is greater than reality.”¹⁶



Engagement Techniques

Focusing Prompts

Focusing prompts are a way for mentors to ask questions that will open up the discussion of a mentee's history. Mentors can prompt further discussion by saying, "Tell me more about that," or "Why do you think that happens?" The mentor is prompting the mentee to think a bit deeper about something in order to uncover it. In addition, focusing prompts can break the ice, interrupt perseveration, stimulate conversation, glean information or knowledge, or assist in framing mentee's personal goals.

Focusing prompts are an opportunity for the mentor to follow the mentee's thoughts and learn more about him or her. It can also help to determine if the mentor and the mentee are a good fit for each other, within the context of the program.

Questions That Stimulate Discussion

Rather than speak in terms of problem-solution, consider challenge-response as a way to frame reactions to life situations. The following are examples of challenge-response style questions:

- Spontaneous Improvement Question: This style of question allows the mentee to spontaneously recall how things have changed in a certain period of time. Example: "What has gotten better since the last time we met?"
- Exception Seeking Question: It is useful for the mentee to recall and then repeat what has worked well for them in the past. Example: "Can you recall a time last week when you did not feel lonely? What would have to happen for this feeling to occur more often?"
- Miracle Question: This question helps the mentee see how the future would be different if the challenge was no longer present. Example: "Suppose one night, while you were asleep, there is a miracle and your challenge was solved or no longer a threat. When you wake up in the morning, how will you discover that the miracle happened? What will you notice?"
- Scaling Question: These questions can help to set personal goals. For instance, "On a scale of one to ten, where would you need to be to feel less depressed? Anxious? Lonely? What would it take for you to move half a step on the scale toward feeling better?"
- Coping Question: These questions are designed to elicit information about mentee resources that will often go unnoticed by them. For example, you might ask the mentee, "With all that is happening in your life, on what or whom do you rely for your strength?"
- Magic Questions: While similar to the Miracle Question, these questions are quite specific. For instance, you could ask the mentee, "Suppose that, magically, you were no longer troubled by depression. How would your life be different? How would you live your life?"

Tips for Asking Questions

- Ask for clarification.
- Ask open-ended questions such as, What was it like when you were feeling good?
- Allow appropriate “wait time.”
- Resist answering for the receiver (communicate patience).
- Ask one question at a time.
- Be prepared to rephrase the question.
- Ask questions that will result in information that is important and necessary.

Allow for Silence

Silence allows individual to be more self reflective and thoughtful about their responses. While this puts pressure on the other person to contribute or participate, it also encourages them to have some ownership in the conversation. When you allow for silence, you indicate empathy, show respect, and allow yourself the opportunity to listen. Allowing silence also empowers the person to think about a response that is meaningful in their life.

What is Self-Disclosure?

“Self-disclosure is a process of communication by which one person reveals information about themselves to another. The information can be descriptive or evaluative, and can include thoughts, feelings, aspirations, goals, failures, successes, fears, and dreams, as well as one's likes, dislikes, and favorites.”¹⁷

When you disclose information about yourself, consider whether or not you are doing so for the mentee’s benefit. You want to be sure that you don’t shift the needs of the mentee to the needs of the mentor, and that you assist the mentee towards recovery, rather than move the relationship toward one of friendship. Maintain the healthy boundaries of your respective roles, to avoid confusing the mentee. If you do reveal information about yourself to the mentee, focus on story-oriented disclosures, as your history may be of value to the mentee.

Giving and Receiving Feedback

Giving feedback to the mentee can be very helpful. It invites a safe place for self reflection and may open up more meaningful dialogue. Consider these aspects when giving feedback:

- Determine the mentee’s readiness to receive your feedback.
- Ask the mentee for permission to provide feedback.
- Be genuine.
- Remind the mentee that your feedback is meant to help them.
- Be specific.
- Direct your feedback toward the behavior.
- Deliver immediate feedback as it is the most effective.

As you are giving feedback, the mentee may give you some feedback. You will need to prepare to receive it from them, too. React as positively as possible to mentee feedback. Listen with an open mind. Take care to hear what the mentee has to say without making excuses or jumping to conclusions. Then evaluate the feedback in the context of the visit.

A Brief Introduction to Cultural Competence

“Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.”¹⁸ Such cultural sensitivity involves developing patterns of competence. As Senior Peer Mentors, you will benefit from becoming more culturally sensitive to meet the individual needs of mentees from different cultures.

Some Aspects of Cultural Competency

Culture means the values, attitudes, beliefs, laws, customs, and experiences that are shared by the members of a group. Cultural Competency means the ability to use a continuum of skills, accumulated over a lifetime, to work effectively across cultures in a way that acknowledges and respects the culture of a person or organization being served.

Becoming Culturally Competent

Janet E. Helms, PhD, director of the Institute for the Study and Promotion of Race and Culture at Boston College, says, “We’re becoming an increasingly culturally complex country,” adding that training in cultural competence should include race and ethnicity, sexual orientation, age, gender, disability status, and other demographic characteristics.”¹⁹ Several experts share many ways you can get that training on your own, including these suggestions:

- **Learn about yourself.** According to Robert C. Weigl, PhD, a psychologist at the Franklin Center says, “Get started by exploring your own historical roots, beliefs and values. Self-assessment makes participants realize the pervasive role culture plays in their lives. It also makes people aware of their own biases while sparking open-minded curiosity about other cultures.”²⁰
- **Learn about different cultures.** If you know you’re going to be providing services to people with unfamiliar backgrounds, seek cultural insight through journal articles and academic books,”²¹ says Ali M. Mattu, clinical psychologist at the Columbia University Clinic for Anxiety and Related Disorders. Private practitioner Pamela A. Hays, PhD, of Soldotna, Alaska says, “One of the best ways to immerse yourself in another cultural worldview is to learn a second language. Plus, learning a language means you’re more able to reach out and connect with people who speak that language”²²



- **Interact with diverse groups.** “Depending on the kinds of cultural experiences you are seeking, you may want to volunteer at community centers, religious institutions or soup kitchens, says Mattu. “Take a friend or two with you,” he recommends, “and spend some time afterward discussing how the experience may have changed your views.”²³

Understanding Cultural Differences in Communication

Awareness of cultural differences will assist you to work with people of a culture that is different than your own. Communication with mentees is key to their success. However, not all cultures communicate in the same way. The aspects of communication listed below will help you to understand how you might respectfully meet the needs of mentees from different cultures.

- **Personal Space:** In the US it is common for people to stand about three feet apart when having a personal conversation. In other cultures, people may typically stand close.
- **Eye Contact and Feedback Behaviors:** In the US, individuals are encouraged to look each other directly in the eye and participate actively in feedback behaviors. In contrast, people from other cultures may show respect or deference by not engaging in eye contact or participating more passively in their body language.
- **Interruption and Turn-Taking Behaviors:** Most Americans have come to expect a conversation to progress in a linear manner while in other cultures it may be more natural for several people to talk at once.
- **Gesturing:** In general, extra gesturing should not necessarily be interpreted as excitement since it can just be an ordinary manner of communication, depending on the speaker.
- **Facial Expression:** Facial expressions differ from culture to culture. It is important to not assume that someone is feeling a certain way based upon his or her facial expression.
- **Silence:** Americans often find it harder to tolerate periods of prolonged silence than do others from different cultures.
- **Dominance Behaviors:** In the US, prolonged eye contact, looking down at someone, hands on hips, and holding the head high are all examples of behavior that may be interpreted as aggressive. This can vary in different cultures.
- **Volume:** Irritation often results when culturally different speakers consider differing levels of volume acceptable. It is important to remember that each individual may be reacting based upon the rules learned in his or her own culture and considered normal by his or her peers.
- **Touching:** Persons from cultures outside the US may perceive someone as cold and aloof if there is not much touching, while Americans may find someone from a different culture a bit intrusive or rude if they touch too frequently.
- **Jargon:** My jargon is not everyone else's jargon. Think about how much jargon you use every day and the complications that can occur.



Strategies for Effective Helping

Helping Others

“Helping is doing something for someone else that they are unable to do for themselves. We have many opportunities in our lives to help others. Perhaps someone you know has become ill, and you help them by arranging and bringing meals to them until they are well enough to do it for themselves. Providing temporary help to someone in need exemplifies kindness and consideration towards the receiver of help, but it also makes us feel wonderful inside when we are able to help others.

Enabling Others

Enabling is entirely a different matter. It is oftentimes confused as help by well-intentioned people. Enabling is doing things for someone else that they can and should be doing for themselves. When we enable people we are preventing them from experiencing the consequences or rewards of their own actions. In other words, not allowing individuals their independence or not empowering them to do for themselves, could increase their dependence on others.

Turning Enabling Behaviors Into Positive Potential

People who help others must learn to redirect their helping efforts by allowing persons to recognize and accept the responsibilities, rewards, and consequences of their own choices, rather than enabling the continuance of unacceptable behaviors to the detriment of everyone involved.”²⁴ Allow the person to solve their own problems by guiding a discussion about how those choices might play out. The person can make their own decisions and live with the consequences of those decisions. You are motivating the person to take responsibility for their actions. When they succeed, they are building self-esteem.

Empathy vs. Sympathy

Empathy “is a basic communication skill which involves putting yourself in another person's shoes. You recognize the feelings and the situation that the other person finds themselves in.”²⁵ Empathy means that you understand where someone is coming from.

Empathy is:

- acknowledging and accepting another person’s point of view and emotions
- the ability to understand another person’s experience and then, to communicate that perception back to that person

Sympathy is empathy plus caring; investing your own emotions with the mentee. Sympathy means that you may agree with and support someone’s point of view, even if they are in a negative frame of mind, which could increase the negative impact of the situation.

“Sympathy is feelings or impulses of compassion; feelings of favor, support, or loyalty; favorable or approving accord, agreement, consonance, or accord.”²⁶

Building Rapport with Mentees

Building rapport and maintaining a positive relationship with a mentee emphasizes the collaborative work between the mentee and the mentor. Here are some of the peer mentoring behaviors that directly contribute to a positive connection:

- Friendliness
- Genuineness
- Respect
- Affirmation
- Empathy
- Unconditional positive regard (mentees can sense indifference or dislike)



Mentoring Reminders

The mentor is in this relationship for the mentee and their perceived relationship with you is most important to their eventual healing. Remember to:

- Convey empathy
- Assist the mentee in taking ownership of their life
- Refrain from making promises
- Make suggestions rather than giving advice
- Be strength-based and provide hope for recovery
- Maintain healthy boundaries by coaching and mentoring the mentee
- Be gentle with yourself. You cannot fix another person. The person has to want the make positive changes toward recovery.

Some other suggestions of which to be mindful:

- Minimize self-disclosure. Be cautious about talking about your experiences.
- Encourage healthy boundaries.
- Practice verbal and nonverbal congruency with mentee.
- Display personal awareness by voice volume, proximity to mentee, etc.
- Normalize the mentee's feelings and thoughts.
- Actively listen without judgment.
- Be attuned to body language.
- Find ways to genuinely encourage the mentee.
- Remind the mentee that he or she is in charge and makes choices.
- Avoid giving advice.
- Communicate hope and recovery.
- Ask permission to move forward.
- Come to visits with a sense of structure.
- Follow occasionally. You do not always have to lead.
- Celebrate the mentee's success and accomplishment.

Empowering the Mentee

Mentors can empower the mentee when they suggest, but not dictate or direct the mentee. Mentee empowerment is a skills that encourages the mentee to make independent healthy choices about their life. The following are practical strategies for assisting a mentees in becoming more empowered:

- Identify personal strengths.
- Practice good listening skills.
- Build decision-making skills.
- Set realistic goals with small steps.
- Learn to ask for help or assistance.
- Build self-confidence.
- Encourage and develop boundaries.

Relationship Building with the Mentee

Like any relationship, a mentoring relationship requires a lot of attention and maintenance skills. But, there are some real “deal breakers” which you must try to adhere. Some common ones include keeping scheduled appointments, showing an interest in the mentee, being attentive and listening, remaining nonjudgmental and noncritical, allowing the mentee to figure out what he or she must do to improve, praising and commending the mentee’s progress, and using (appropriate) humor.

Barriers to Engagement

Resistance is an active process. It is a fundamental obstacle to positive mentoring outcomes. It is also a natural part of any change or recovery process. Resistance exists because change and pain are often more difficult to face than the status quo. Even when something is not working, people frequently resist change. Resistance is a normal mentee reaction. Its presence should be anticipated and not come as a surprise to the mentor. However, mentee resistance should be addressed. Resistance dissipates when a person has the opportunity to buy in to the change process and recognize some personal gain in the outcome.

People who resist change can display behaviors such as being difficult, unmotivated, stubborn, noncompliant, or oppositional. Resistance can also be a defense mechanism to counter what a mentee believes is unwanted or unwarranted influence or something that they feel is not appropriate for them. If you acknowledge a mentee’s resistance and address it, you increase the likelihood of positive outcomes. Here are a few general strategies:

- Normalize the presence of the mentee’s resistance
- Treat resistance with respect
- Recognize that excessive questioning of mentee resistance forces confrontation
- Avoid arguing as it tends to create more resistance
- Give the mentee the power for self-direction

Basic Mentoring Skills

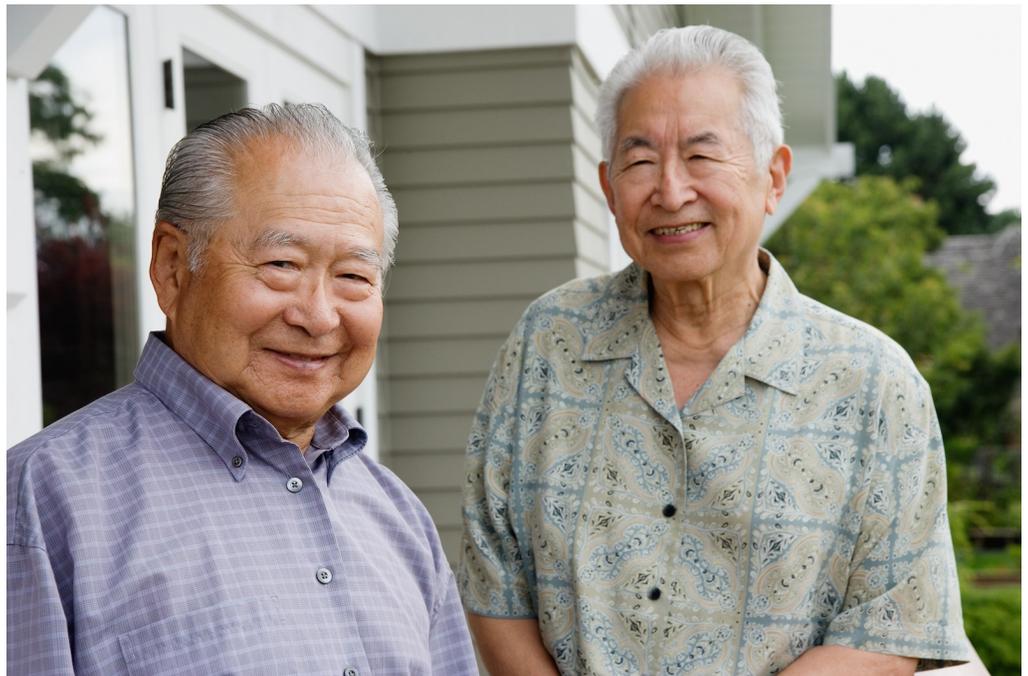
The basic mentoring skills are grounded in the person-centered approach to therapy that was originally proposed by psychologist Carl Rogers during the 1940s and 1950s. In proposing a model of non-directive therapy that was mentee-centered, Rogers said there are three key elements:

- Genuineness – A need to share feelings honestly. By modeling this behavior, the mentor can help teach the mentee to also develop this important skill.
- Unconditional positive regard – Acceptance of the mentee for who they are and display support and care no matter what the mentee is facing or experiencing
- Empathic understanding – The need to be reflective, acting as a mirror of the mentee’s feelings, thoughts
- Willingness to suspend judgment
- Use of Open-Ended Questions – Questions that are non-directive and encourage the mentee to talk, “Can you tell me more,” “How do you see your current situation,” etc.
- Reflective Listening – Repeating back to the mentee what you are seeing or hearing
- Summarizing – Summarize the main points both the mentor and the mentee have made
- Silence – When the mentee is silent, you can also elect to remain silent. Non-judgmental silence indicates acceptance and a low-pressure way to move the conversation forward without making the mentee feel as if you are always trying to get things done quickly

What Makes a Competent Senior Peer Mentor?

Competency can be a relative concept. Here are some of traits that seem to contribute to an individual becoming an excellent mentor:

- Self-awareness including biases and prejudices
- Interest in other people including caring and curiosity
- Good boundaries and personal effectiveness in implementing them
- The ability to segregate volunteer work from the rest of the mentor’s life
- A lifelong learner
- Flexible ideas and approaches
- Resilience and the ability to demonstrate being resilient
- Community connectedness; knowing what is available and how to access it



Definition of a Volunteer:

A volunteer is best described by their actions.

A volunteer sits in class learning techniques to help alleviate stress, anxiety and the depressed feeling of others.

A volunteer reaches out to complete strangers to build a communication bridge for them to cross.

A volunteer is one with the priceless gift of listening. And the one with the true insight into the word, 'confidentiality.'

A volunteer travels to areas they have never been; they walk into homes that others would turn from.

A volunteer does not judge.

A volunteer leaves behind the feeling of hope that someone care.

A volunteer comes back. And comes back. And, again.

Are volunteers relentless in their actions? Do they possess some mysterious "glue" that quickly adheres them to others? Do they have courage...to change others?... to let others remain as they are? . . . to keep trying?

A volunteer contains thousands of attributes. Each attribute carefully honed to perfection, crafted for use, modified for stability.

And to the volunteers, thank you, for planting solid footsteps that are a gift and can be repeated through time.

—Linda

Section 4:

Mental Health Issues in Older Adults



Section 4: Mental Health Issues in Older Adults

There are several mental health conditions that are common among older adults as well as many effective strategies to use that will assist with the opportunities to impact overall health and wellness. You will learn about the symptoms, early warning signs, and risk factors of several conditions that will assist individuals to move towards recovery. The following information will give you some basic information that can be used to help you to understand the components of these mental health issues.

Studies reveal that the older adult population will soon be the largest population throughout our nation. As we increase awareness and literacy around mental health conditions among older adults, we will likely increase the number of individuals receiving treatment.

Chronic Loneliness

Most people feel loneliness at some time throughout their life. Loneliness is an essential human emotion; it may function as an alarm that can motivate someone to change an uncomfortable situation. Being alone does not necessarily mean being lonely. Being alone can be a pleasure and loneliness can happen in a crowd. Loneliness becomes a significant challenge in its own right only when a person has no way to mitigate the loneliness. At that point, loneliness morphs from a useful warning to a chronic disability.

According to a recent study from Brigham Young University, isolation and loneliness are “as bad for a person’s health as smoking 15 cigarettes a day or being an alcoholic. People who feel lonely have a 26% greater risk of premature death. People living alone or socially isolated is even more damaging to a person’s health, increasing the risk of early death by roughly 30%.”²⁷

Chronic loneliness is a serious challenge to many older adults and people living with disability. Fortunately, loneliness can be overcome, although doing so takes some initiative.

Negative thinking often lends itself to feelings of loneliness. Feeling appreciated leads to not feeling alone. Consider the following insights:

- Loneliness can be defined as a state of feeling that one does not belong or is not accepted. It is a feeling of not being included.
- Virtually all people possess a fundamental need for companionship and intimate relationships. However, do not assume it is always true. Listen and ask.
- Longevity dramatically increases the likelihood of experiencing loneliness. As we age, all of us are likely to have more time alone and we will need to adapt to increased aloneness. On the contrary, we can develop new contacts to help us avoid feeling lonely.
- The causes of loneliness include fear, rejection, failure, a self-defeating cycle of isolation, and loss of mobility.
- Loneliness condemns people to even greater loneliness.
- Being alone is OK when it is the person’s choice. Being alone is not OK when it is not the person’s choice.

- Curing loneliness is akin to climbing a ladder. Each rung takes the person closer to the goal.
- Many older adults or people living with chronic illness and disability experience loneliness as shame. They frequently see loneliness as a moral weakness.
- Focusing on loneliness can lead to depression.

Make an Action Plan to Move from Loneliness

Involve yourself in activities that de-amplify your loneliness. Make a conscious decision to move to positive behaviors. For example, go to a library to hear a local speaker, go to a senior center for an activity, invite a friend over for a visit, etc. You can also:

- collect good thoughts
- choose to be happy
- develop a routine
- treasure your alone time
- do positive, creative activities such as singing, dancing, drawing, painting, cooking, baking, playing an instrument, listening to music, reading, and writing
- make new friends and make an effort to reach out to people
- have at least one intimate, confiding relationship
- establish telephone and/or computer contacts
- volunteer
- commit to lifelong learning in some form

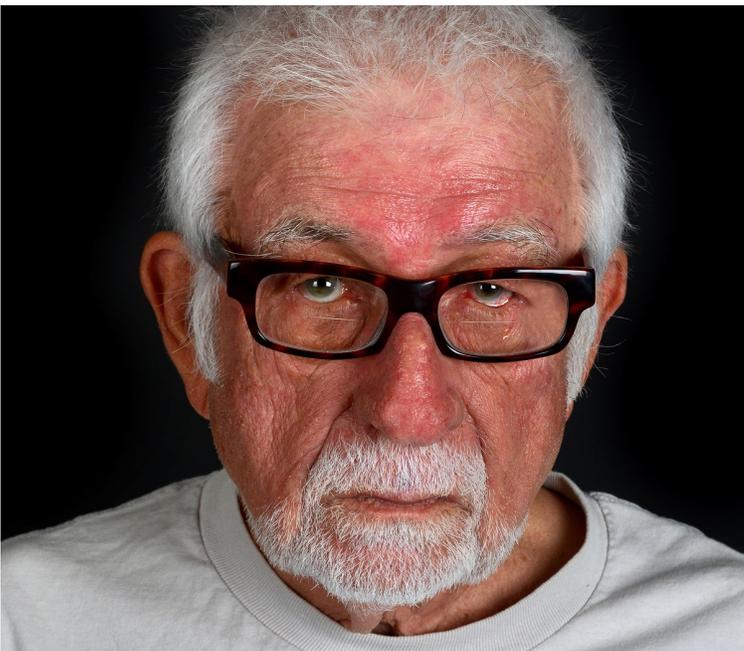
Grief and Loss

One of the major life occurrences we all share is having to deal with various types of losses throughout our lives. Older adulthood has been characterized as the “season of loss.”

Major Types of Loss

Major types of loss include material, functional, and systemic loss. Material losses include:

- Loss of a physical object or of familiar surroundings—home
- Extrinsic Loss—silver dollar collection, vacation cabin, vehicle
- Intrinsic Loss—family recipes, heirloom glassware, photographs
- Relationship loss
- Moving, divorce, job change, change in a personal friendship, death
- Intrapsychic loss—the experience of losing an image of yourself, what might have been, abandonment of future plans, or the loss of a dream



Functional loss may include:

- Loss of muscular or neurological functions; arthritis, dementia, ALS, neuropathy
- Loss of a specific role or of one's accustomed place in a social network, e.g., retirement, children moving from home, role in the family.

Systemic loss may include:

- Loss due to changes in interactional systems, e.g., family members' geographical distance

Primary and Secondary Losses

- Primary Loss—alters relationships and affects well-being, e.g., death, injury, unemployment, separation from long-time friends
- Secondary Loss—loss that emerges as a result of the initial circumstance; collateral loss; loss of independence, role of being a productive person, changes in one's appearance, isolation, decline in self-esteem, decline in earning power or income

Every person's loss is unique. Almost all primary losses trigger adjustments in the lives of older adults. Many primary losses are recognized as real by family, friends, and community, but often secondary losses go unrecognized or ignored.

Reconciling Loss

Experiencing loss and the grief that comes with loss is the most concrete proof that you are an average, real human being. Once you accept that loss and greater loss with aging is a part of life, reconciling loss can become more manageable. No one else will be able to understand your loss. Someone who says they understand means well, but only you can truly process the loss. No one else can do it for you.

The presence or absence of tears also has no relationship to a person's feelings of pain and suffering from the loss. With a death, the loss ends a life. For most loss, there are residual attachments. After any loss it is healthy to move on with your life, as best as you can, and not feel guilty about that. The single most important factor in healing from any loss is having and accepting support from other people. Even if you are not comfortable talking about your feelings under normal circumstances, it is important to express them when reconciling loss.

Supporting Someone Who is Grieving

Grief is when an individual is experiencing deep sorrow, especially that which is caused by another person's death. People tend to grieve in many different ways and there is no correct or standard way to grieve. Here are some useful suggestions to support someone who is grieving:

- Avoid presumptions that all grief is from loss of a person. Loss can include loss of a pet, home, mobility, dream, etc.
- Avoid presumptions that the person lost was a loved one, the relationship may not fit that description.

- Grieving is not time-limited, nor does grief follow a linear path. It is not helpful to tell some to snap out of it.
- Encourage an individual to grieve according to what feels right to them.
- Assist the person who is grieving as they begin to identify secondary losses and work through unfinished business.
- Avoid clichés (e.g., gone to a better place, she or he was taken for a reason, etc.), but allow the mentee to express them if they wish.
- Assist the person who is grieving with identifying the practical challenges following a loss and cautioning quick or unwise decisions.

Most importantly, you bring presence to a person experiencing grief. Listen if they want to talk, be silent if they do not want conversation.

Being with a Person at End-of-Life

Some suggestions for encouraging a person to open up, include:

- Avoiding the phrase, “I know how you feel.” This statement is presumptuous.
- Watching out for the question, “What would you do?”
- Becoming comfortable as a follower in a conversation.
- Respecting the use of euphemisms, e.g., “my problem,” “the disease,” etc.
- Adjusting your language accordingly.
- Remembering that “big talk” usually begins with “small talk.”
- Avoiding feeling frustrated or impatient with the same old conversations. Such small talk provides a vital trust-building function.
- Asking for stories.
- Asking scary questions such as “Are you fearful?” Many people are grateful for the opportunity to verbalize things that they may withhold from other people they want to protect.

Suggestions for “being with” a person at the end of their life:

- Sometimes you will recognize the person wants to take the lead in the conversation.
- Learn how to “be with” emotional and spiritual pain rather than trying to alleviate them.
- Allow expression of feelings—guilt, anger, sorrow, depression, fear—without judgment.
- Encourage hope. Help the person who is dying to discover their own hope within themselves.
- Healing can become a tangible expression of hope.
- Listening is profoundly healing.

Some suggestions for caring for the dying:

- Learn to acknowledge your own feelings and emotions.
- Take care not to contribute to the isolation of the person who is dying.
- Do not take on the anger and rage of the person who is dying personally.
- Share humor.
- Be yourself. Relate to the person who is dying.
- Do not be afraid to touch the person who is dying.

- Respect your own needs. Honor your boundaries.
- Trust your innate compassion and intuition to lead the way to caring for the person who is dying. Bring both strengths and vulnerabilities to the bedside.
- Be dependable.
- Do not try to be too wise; do not always try to search for something inspirational or profound to say.
- If you cannot answer a question, simply say so.
- Let the mentee lead the discussion of anything touching on spiritual or religious matters.

Depression

Most people experience some level of depression throughout their life. While depression is a common challenge among older adults, it is not a normal part of growing older. Studies show that most older adults are quite satisfied with their lives despite various challenges. Depression is a medical condition and if you are feeling depressed, you should make an appointment to see your physician.

Risk Factors and Early Warning Signs for Depression

“Depression often begins in the teens, 20s or 30s, but it can happen at any age. More women are diagnosed with depression than men, but this may be due in part because women are more likely to seek treatment. Researchers have identified certain factors that seem to increase the risk of developing or triggering depression, including:

- Certain personality traits, such as having low self-esteem and being overly dependent, self-critical or pessimistic
- Traumatic or stressful events, such as physical or sexual abuse, the loss of a loved one, a difficult relationship or financial problems
- Childhood trauma or depression that started when you were a teen or child
- Blood relative with a history of a mental health condition, alcoholism or suicide
- Being lesbian, gay, bisexual, or transgender in an unsupportive situation
- History of other mental health disorders, such as anxiety disorder, eating disorders, or post-traumatic stress disorder
- Abuse of alcohol or illegal drugs
- Serious or chronic illness, such as cancer, stroke, chronic pain, or heart disease
- Certain medications, such as some high blood pressure medications or sleeping pills”²⁸



Symptoms of Depression

Situations in life can make us sad or even depressed, but typically the person experiencing the situation regains a positive attitude as the situation is resolved. The difference between situational depression and clinical depression is the level of intensity of the person's feelings and the duration of the depression.

“Although depression may occur only one time during your life, usually people have multiple episodes of depression. During these episodes, symptoms occur most of the day, nearly every day and may include:

- Feelings of sadness, tearfulness, emptiness, or unhappiness
- Angry outbursts, irritability or frustration, even over small matters
- Loss of interest or pleasure in normal activities such as sex, hobbies, or sports
- Sleep disturbances, including insomnia or sleeping too much
- Tiredness and lack of energy, so that even small tasks take extra effort
- Changes in appetite—often reduced appetite and weight loss, but increased cravings for food and weight gain in some people
- Anxiety, agitation, or restlessness—for example, excessive worrying, pacing, hand-wringing, or an inability to sit still
- Slowed thinking, speaking, or body movements
- Feelings of worthlessness or guilt, fixating on past failures, or blaming yourself for things that are not your responsibility
- Trouble thinking, concentrating, making decisions, and remembering things
- Frequent thoughts of death such as suicidal thoughts or suicide attempts
- Unexplained physical problems, such as back pain or headaches

For some people, depressive symptoms are so severe that it's obvious something isn't right. Other people feel generally miserable or unhappy without really knowing why.”²⁹

Symptoms of Depression in Older Adults

“Depression is not a normal part of growing older and it is important for the older adult to understand that depression is treatable. Unfortunately, depression often goes undiagnosed and untreated in older adults, and they may feel reluctant to seek help. Symptoms of depression may be different or less obvious in older adults, including:

- Memory difficulties or personality changes
- Fatigue, loss of appetite, sleep problems, aches, loss of interest or pleasure in daily activities, which are not caused by a medical condition or medication
- Often wanting to stay at home, rather than going out to socialize or doing new things
- Suicidal thinking or feelings, especially in older men”³⁰

“The difficult changes that many older adults face such as bereavement, loss of independence, and health problems can lead to depression, especially in those without a strong support system. Older adults tend to identify more physical symptoms rather than

the emotional signs and symptoms of depression, and so the problem often goes unrecognized. Depression in older adults is associated with poor health, a high mortality rate, and an increased risk of suicide, therefore diagnosis and treatment are extremely important.”³¹

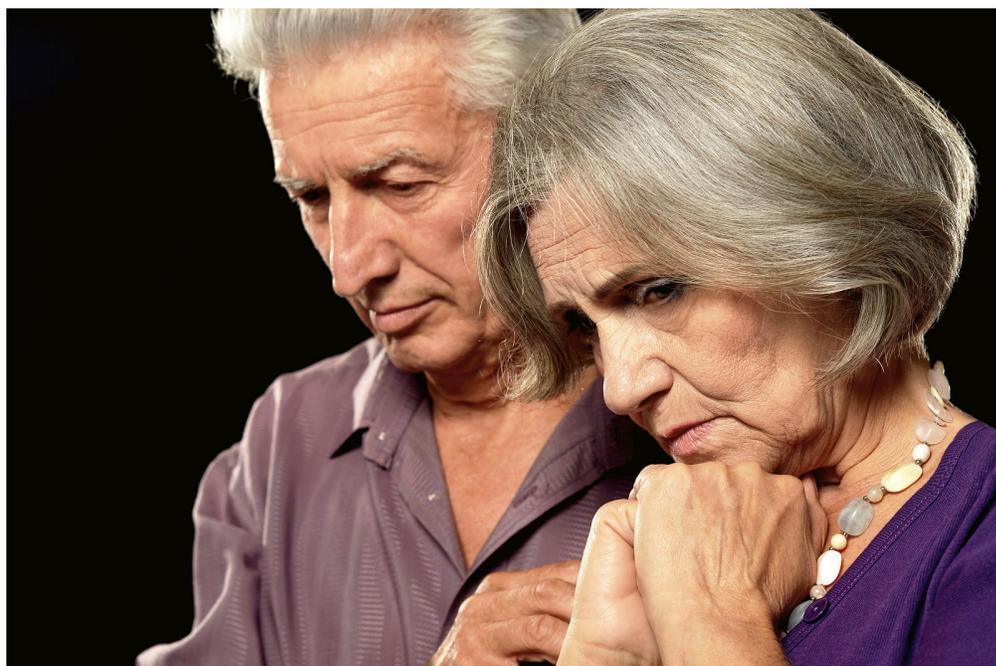
“According to the Centers for Disease for Disease Control and Prevention (CDC), someone who is depressed has feelings of sadness or anxiety that last for weeks at a time. He or she may also experience:

- Feelings of hopelessness and/or pessimism
- Feelings of guilt, worthlessness, and/or helplessness
- Irritability, restlessness
- Loss of interest in activities or hobbies that were once pleasurable
- Fatigue and decreased energy
- Difficulty concentrating, remembering details and making decisions
- Insomnia, early-morning wakefulness, or excessive sleeping
- Overeating or appetite loss
- Thoughts of suicide or suicide attempts
- Persistent aches or pains, headaches, cramps, or digestive problems that do not get better, even with treatment”³²

How to be Helpful

When someone is depressed, it is important to recognize that depression is treatable and recovery is possible. Things you can do to help:

- Encourage the person to seek professional help.
- Listen non-judgmentally.
- Give reassurance.
- Celebrate successes toward a better outlook.
- Connect the individual with family, friends, or coworkers.
- Provide empathy.
- Give the individual information about depression.



Suicide

What is Suicide?

Suicide “is the act of intentionally causing one’s own death.”³³ It is often times a way for people to escape pain or suffering. When someone ends their own life, we say that they died by suicide or completed suicide. A suicide attempt means that someone tried to end their life, but did not die.

Oregon’s Suicide Statistics

“Nationwide, the elderly have the highest suicide rate of any age group, and in Oregon, the elderly suicide rate is among the highest in the country. In a report by Oregon Public Broadcasting (OPB) Colin Fogarty looked at the reasons behind the trend. According to Fogarty, ‘Nationally for every 100,000 people older than 65, 15 to 20 commit suicide every year. Yeates Conwell, a suicide researcher at the University of Rochester, says the profile of a senior citizen most at risk for suicide is a white man who faces mounting health problems. But Conwell says much about the phenomenon remains unknown.’ In Oregon, as in other rural Western states, the rate of elderly suicides is alarmingly high. In fact, Lisa Millet with the Oregon Department of Human Services says at 125 a year, about as many older Oregonians died by suicide as by car crashes.’”³⁴

Some Common Misconceptions About Suicide

“The following are common misconceptions about suicide:

- ‘People who talk about suicide won't really do it.’ Research indicates that this is not true. Almost everyone who commits or attempts suicide has given some clue or warning. Do not ignore suicide threats. Statements like ‘You'll be sorry when I'm dead,’ ‘I can't see any way out,’—no matter how casually or jokingly said, may indicate serious suicidal feelings.
- ‘Anyone who tries to kill him/herself must be crazy.’ Not True. Most suicidal people are not psychotic or insane. They may be upset, grief-stricken, depressed or despairing. Extreme distress and emotional pain are always signs of mental illness but are not signs of psychosis.
- ‘If a person is determined to kill him/herself, nothing is going to stop him/her.’ Research indicates that this is not true. Even the most severely depressed person has mixed feelings about death, and most waiver until the very last moment between wanting to live and wanting to end their pain. Most suicidal people do not want to die; they want the pain to stop. The impulse to end it all, however overpowering, does not last forever.
- ‘People who die by suicide are people who were unwilling to seek help.’ Research indicates that this is not true. Studies of adult suicide victims have shown that more than half had sought medical help within six months before their deaths and a majority had seen a medical professional within one month of their death.
- ‘Talking about suicide may give someone the idea.’ Research indicates that this is not true. You don't give a suicidal person ideas by talking about suicide. The opposite is true— bringing up the subject of suicide and discussing it openly is one of the most helpful things you can do.’³⁵

Risk Factors and Early Warning Signs for Suicide

“There are several important risk factors for suicide. These include but are not limited to:

- Depression
- Prior suicide attempts
- Marked feelings of hopelessness
- Comorbid general medical conditions that significantly limit functioning or life expectancy
- Pain and declining role function (e.g., loss of independence or sense of purpose)
- Social isolation
- Family discord or losses (e.g., recent death of a loved one)
- Inflexible personality or marked difficulty adapting to change
- Access to lethal means (e.g., firearms)
- Alcohol or medication misuse or abuse
- Active plan
- Impulsivity in the context of cognitive impairment”³⁶

Symptoms of Suicide

In *The Suicidal Mind*, Edwin Shneidman suggested that certain psychological characteristics are common to suicidal individuals. The commonalities were a factor in at least 95 percent of people who are committed to dying by suicide. Knowledge of the commonalities yields tremendous appreciation for avenues of prevention. The commonalities include:

- Purpose is to seek a solution: A suicidal person is seeking a solution to a problem that is generating intense suffering within him or her.
- Goal is cessation of consciousness: The anguished mind of a suicidal person interprets the end of consciousness as the only way to end the suffering.
- Stimulus is psychological pain: A suicidal person experiences “psychache”—an intolerable emotion, unbearable pain, or unacceptable anguish.
- Stressor is frustrated psychological needs: A suicidal person feels pushed toward self-destruction by psychological needs that are not being met (e.g., need for achievement, nurturance, affection, or understanding).
- Emotion is hopelessness or helplessness: A suicidal person feels despondent and that the situation is utterly unsalvageable.
- Cognitive state is ambivalence: Suicidal people wish to die and they simultaneously wish to be rescued.



- Perpetual state is constriction: The mind of a suicidal person is constricted in its ability to perceive options and, in fact, mistakenly sees only two choices—either continue suffering or die.
- Action is escape: It is the ultimate escape beside which other options—such as running away from home, quitting a job, deserting a family, or leaving a spouse—pale in comparison.
- Interpersonal act is communication of intention: Many individuals intent on dying by suicide emit clues of intention, signals of distress, whimpers of helplessness, or plea for intervention.
- Pattern is consistent with lifelong styles of coping: A person’s past tendency for black-and-white thinking, escapism, control, defeatism and the like could serve as a clue to how far he or she might deal with a present crisis.³⁷

What to Do When Someone is Suicidal

A person who is considering suicide will likely not initiate asking for help. Bringing up the subject of suicide and engaging in an open discussion can be one of the most liberating things you can do because it relieves the suicidal person of the incredible sense of isolation. Asking about suicide relays that another person has insight into their psychological pain and cares about their well-being.

The impulse to end one’s life by suicide, however overpowering, does not last forever. Suicide is often preventable if a caring and nonjudgmental person can hold someone through the intensity of a suicidal crisis. Remember, if you do not feel confident or competent to engage a person who is likely to experience suicidal thoughts and ideas, find someone who is willing to make the initial contact. It is OK for you to make the decision to step back and allow someone else to engage the person.

Talking with Someone Who is Suicidal

When talking with someone who you think is suicidal, remember these techniques:

- Remain calm.
- Listen non-judgmentally.
- Remember, suicide is not the problem.
- Reflect back feelings and paraphrase: “What I hear you say is that you are in a great deal of pain and feel hopeless.” “Am I really getting a sense of what you are feeling?”
- Tame your own fears.
- Encourage them not to make any serious, irreversible decisions while in a crisis.
- Tell them clearly that you do not want them to die.
- Reduce the risk of suicide by making death by suicide difficult.
- Be responsive to clues and warning signs.
- Calibrate your initial comments to your perceptions.
- Ask about their current state: “Sometimes when people feel sad, they have thoughts of harming themselves. Do you have such thoughts? Are you thinking of killing yourself?”
- Contrary to popular belief, asking about suicide does not put ideas into a person’s head. You will not trigger a suicide.

- Ask about the person's thoughts. Ask about the plan, method, and means. Are they lethal? Available?
- Ask about probability. "How likely do you think it is you will act on these thoughts of hurting yourself or ending your life sometime in the next over the next week?"
- Ask about prevention. "Is there anything that would prevent you from harming yourself?"

However, don't:

- Leave the person alone.
- Assume the person is simply seeking attention.
- Promise to keep what they share with you a secret.
- Offer simple solutions.
- Try to take away or minimize their pain.
- Be judgmental.
- Try to be a therapist.

NorthWest Senior and Disability Services' Suicide Risk Assessment Policy and Procedure

"Northwest Senior and Disability Services (NWSDS) is committed to ensuring that all individuals receive appropriate services when they are exhibiting symptoms of harm to themselves. Over 5,000 older Americans die by suicide annually. Oregon has the fourth highest suicide rate among older adults in the United States. Suicide is particularly acute among older males, occurring nine times more frequently in the male population.

Warning Signs

Research indicates there are a number of warning signs. The greater number of warning signs present increases the likelihood of suicide. These warning signs include, but are not limited to:

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or buying a gun
- Talking about being a burden to others
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Increase use of alcohol or drugs



- Acting anxious or agitated; behaving recklessly
- Sleeping too much or too little
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

In the event that you are working with an individual either face-to-face, on the telephone, in the community, or by electronic communication, it is essential to follow this protocol.

Assess the Level of Risk

Assess the level of risk by asking these direct questions:

- Are you having thoughts of suicide OR are you thinking about killing yourself? Note: You may need to ask these questions more than once in the same conversation. If they answer yes, then ask:
 - Do you have a plan of when you might kill yourself? If they answer yes, then ask:
 - What is your plan? If they provide a detailed plan, such as a time and place in which they may facilitate the plan, then ask:
 - How are you going to kill yourself? Do they have the means to follow through with the plan (for example: a gun in their possession, stock piling medication, or any other means):

If an individual eludes to **ALL** of the following, they are at imminent risk.

- Suicidal or having thoughts of killing self, and
- Has a plan to kill themselves, and
- Has access to a means to follow through with the plan.

Plan of Action – Imminent Risk

Stay with the individual and call 911 immediately. Communicate to the 911 dispatcher the individual is having thoughts of suicide, has an active plan to kill themselves, and the individual has the means to follow through with plan.

In the event that you are on the phone with an individual who is at imminent risk, Spark (IM) a co-worker or manager to assist in calling 911 so you can remain on the phone with the individual. If the individual is not willing to stay on the phone or hangs up the phone, proceed with the protocol and call 911 immediately.

Plan of Action – No Plan or Means

An individual is not at imminent risk if they indicate/state/elude that they are:

- Having thoughts of suicide with no plan or means

If they are having thoughts of suicide, refer the individual to local resources, such as a mental health provider, private therapist, psychiatric crisis center, or the National Suicide Prevention Lifeline. It is your responsibility to provide a *warm transfer* of the individual to the professional provider. This would include having a verbal conversation with the professional and the individual before the individual leaves the office or disconnects from a

telephone call. Also, work to identify and connect the individual with a natural support, such as a family member, neighbor, relative, or friend. It is best to call all resources while the individual is present with you or while they are on the phone with you.

Who to Call

Area Served	Agency and Brief Description	Telephone
All NWSDS Counties	National Suicide Prevention Lifeline A 24-hour, toll-free, confidential suicide prevention hotline.	1-800-273-8255
Marion, Polk, and Yamhill	Psychiatric Crisis Center 24-hour crisis intervention services offered face-to-face or by telephone. Northwest Human Services A 24-hour crisis and information hotline.	503-585-4949 503-581-5535 or 1-800-560-5535
Clatsop	Clatsop County Behavioral Healthcare A 24-hour crisis line.	503-325-5724
Polk	Polk County Behavioral Health A crisis line available Monday through Friday, 8 am to 5 pm.	503-623-9289
Tillamook	Tillamook Family Counseling Center A 24-hour crisis line.	503-842-8201
Yamhill	Yamhill County Health and Human Services A crisis line available Monday through Friday, 8 am to 5 pm.	503-434-7523

Crisis Intervention Form

Make sure to verbally notify your manager about the situation immediately. Complete a Crisis Intervention Form within one business day of the event and submit the report to your manager. If your manager is not available, submit the report to the program manager.

Safety

Things to remember for safety:

- Remain calm/grounded and listen non-judgmentally while interacting with the individual in crisis.
- Remain present with the individual experiencing a crisis.
- Seek and ask for someone nearby to assist you with the individual in crisis.
- Distract the individual until professional help arrives. For example: What did you eat today? What do you do to relax? Tell me about your home.

If someone reports to you that an individual is having feelings or thoughts of suicide, it is important to take this seriously. It is your responsibility and you are required to follow the protocol listed above to assist the individual through the crisis.³⁸

Anxiety Disorders in Older Adults

“Until a few years ago, anxiety disorders were believed to decline with age. That’s because older adults are less likely to report psychiatric symptoms and more likely to emphasize their physical complaints. But experts now recognize that aging and anxiety are not mutually exclusive: Anxiety is as common among older adults as with the younger population. In fact, many older adults with an anxiety disorder had one when they were younger.”³⁹

While some anxiety is considered a normal response to life events, some anxiety can be disabling. Anxiety can be higher in intensity or longer in duration than it should be. This anxiety is typically classified as an anxiety disorder which is characterized by unpleasant and overriding mental tension and apprehension with no apparent identifiable cause.

Anxiety disorders are a common mental health condition in older adults. Anxiety disorders last a long time but they do get better with treatment. In older adults, anxiety disorders may occur at the same time as other illnesses such as depression, heart disease, diabetes, and other serious medical conditions. However, you should not assume that anxiety disorders always occur in older adults who experience these illnesses.

“About 10% of adults aged 65 and older experience a diagnosable anxiety disorder (Byers, Yaffe, Covinsky, Friedman, & Bruce, 2010). Over their lifetimes, about 15 percent of those who survive past 65 will have had an anxiety disorder (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005).”⁴⁰

Like depression, developing an anxiety disorder in later life is not a normal part of aging. All anxiety disorders involve a complex set of physiological, emotional, mental, and behavioral responses whose primitive purpose is keeping us safe.

“Anxiety may affect twice as many older adults as depression, according to new research. Researchers say generalized anxiety disorder (GAD) may be the most common mental disorder among the elderly, although little is known about how to treat the disorder among older adults.

‘Studies have shown that generalized anxiety disorder is more common in the elderly, affecting 7% of seniors, than depression, which affects about 3% of seniors. Surprisingly, there is little research that has been done on this disorder in the elderly,’ says researcher Eric J. Lenze, MD, assistant professor of psychiatry at the University of Pittsburgh School of Medicine.

‘Due to the lack of evidence, doctors often think that this disorder is rare in the elderly or that it is a normal part of aging, so they don't diagnose or treat anxiety in their older patients, when, in fact, anxiety is quite common in the elderly and can have a serious impact on quality of life,’ says Lenze.

Anxiety in the Elderly

Lenze has published work on the topic of treatment for anxiety disorders among older adults and presented an overview of the issue [on May 20, 2006,] at the Annual Meeting of the American Psychiatric Association, in Toronto.

Researchers say it's normal for older adults to worry more about things like deteriorating health and financial concerns as they age, but elderly with generalized anxiety disorder worry excessively about routine events and activities for six months or more.

This constant state of worry and anxiousness may seriously affect older people's quality of life by causing them to limit their daily activities and have difficulty sleeping. If untreated, GAD may also lead to depression. Other conditions considered anxiety disorders include phobias, panic disorder, and obsessive compulsive disorder."⁴¹

Panic Attack Definition

Experiencing occasional anxiety is a normal part of life. However, people with anxiety disorders frequently have intense, excessive and persistent worry and fear about everyday situations. Often, panic disorder "involve repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes"⁴² which is often known as panic attacks. The most common type of anxiety disorder is a panic attack.

Risk Factors for Anxiety Disorders

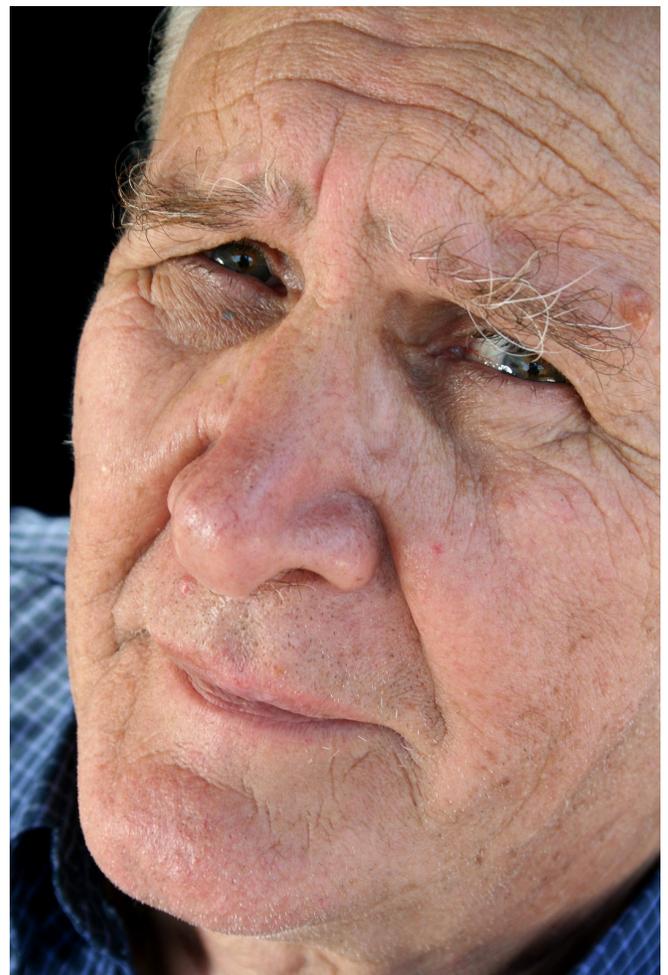
There are several contributing factors which may prompt anxiety in older adults. They include the following risk factors:

- Alcohol and drug use
- Stressful or traumatic events
- Distressing and uncontrollable event

It is not uncommon for someone with an anxiety disorder to also suffer from depression or vice versa. Nearly one-half of those diagnosed with depression are also diagnosed with an anxiety disorder.

"Common Signs and Symptoms

- Feeling nervous
- Feeling powerless
- Having a sense of impending danger, panic or doom
- Having an increased heart rate
- Breathing rapidly (hyperventilation)
- Sweating
- Trembling



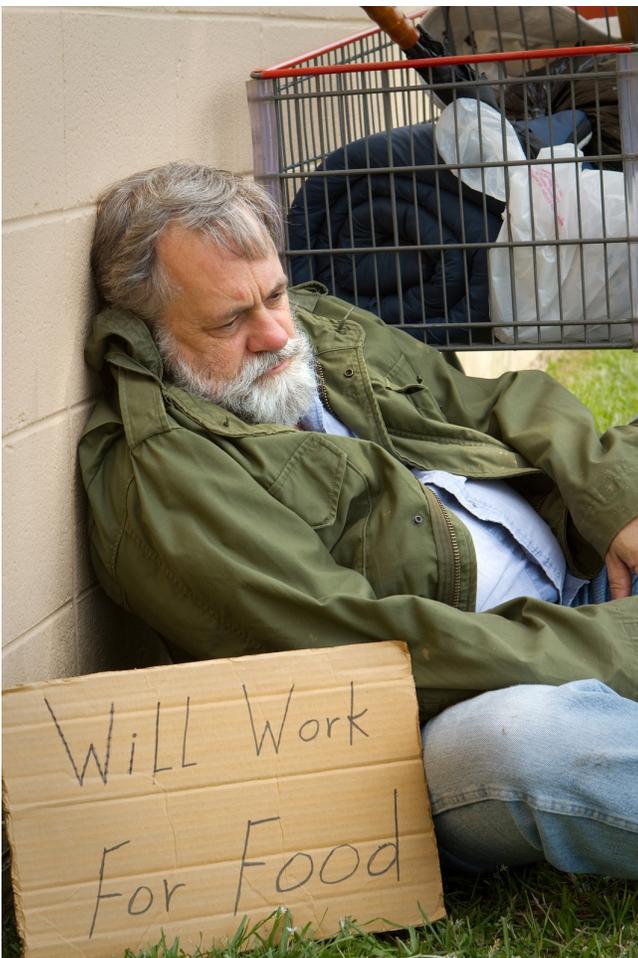
- Feeling weak or tired
- Trouble concentrating or thinking about anything other than the present worry”⁴³
- Ongoing stress and anxiety
- Medical conditions
- Previous episode of depression or anxiety
- Family history of anxiety
- Irritability
- Decreased memory
- Avoidance of situations
- Unrealistic or excessive fear or worry
- Confusion

Post-Traumatic Stress Disorder

Definition of PTSD

Post-traumatic stress disorder (PTSD) is described as an overwhelmingly traumatic event that is re-experienced, causing intense fear, helplessness, horror, and avoidance of stimuli associated with the trauma. A person who develops PTSD may have been the one who was harmed, have a loved one who was harmed, or have witnesses a harmful event.

Post-traumatic stress disorder can develop following a traumatic event that threatens one’s safety or makes the person feel helpless.



Traumatic Events That Can Lead to PTSD

- “Combat exposure
- Childhood neglect, sexual [and physical] abuse
- Sexual assault
- Physical attack
- Being threatened with a weapon
- Natural disasters
- Assault
- Kidnapping
- Terrorist attacks”⁴⁴

Warning Signs

Trauma is experienced differently by each person. “Symptoms do not usually just pop up out of the blue. They are usually preceded by some warning signs. These can be many (sometimes minor) things, such as the experience of certain emotions, changes in thoughts, or changes in behavior.”⁴⁵

Symptoms of PTSD

“Post-traumatic stress disorder symptoms may start within three months of a traumatic event, but sometimes symptoms may not appear until years after the event. These symptoms cause significant problems in social or work situations and in relationships.”⁴⁶

Symptoms of PTSD include:

- Upsetting memories
- Flashbacks
- Nightmares
- Feelings of intense distress
- Avoiding activities
- Feeling emotionally numb
- Loss of interest in things one previously enjoyed
- Sleep changes

Intensity of Symptoms

“PTSD symptoms can vary in intensity over time. You may have more PTSD symptoms when you're stressed in general, or when you run into reminders of what you went through. For example, you may hear a car backfire and relive combat experiences. Or you may see a report on the news about a sexual assault and feel overcome by memories of your own assault.”⁴⁶

Risk Factors

“People of all ages can have post-traumatic stress disorder. However, some factors may make you more likely to develop PTSD after a traumatic event, such as:

- Experiencing intense or long-lasting trauma
- Having experienced other trauma earlier in life, including childhood abuse or neglect
- Having a job that increases your risk of being exposed to traumatic events, such as military personnel and first responders
- Having other mental health problems, such as anxiety or depression
- Lacking a good support system of family and friends
- Having biological (blood) relatives with mental health problems, including PTSD or depression”⁴⁷

Trauma-Informed Care Movement

A State of Being Because of Adverse Childhood Experiences

Becoming ‘trauma-informed’ means recognizing that people often have life experiences which have created trauma in their lives. People who have been traumatized need to have their trauma acknowledged and have support from others. Often, trauma survivors can be re-traumatized by people who simply who are unaware of how to recognize and respond to those survivors.

Trauma is an event that is extremely upsetting and at least temporarily overwhelms a person's internal resources. It:

- Can be a single event
- Most often is multiple events over time (complex, prolonged trauma)
- Is an interpersonal violence or violation
- Is most damaging when it is at the hands of an authority figure

Trauma-Informed Approach

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) concept of a trauma-informed approach, "A program, organization, or system that is trauma-informed:

- Realizes the widespread impact of trauma and understands potential paths for recovery
- Recognizes the signs and symptoms of trauma in mentees, families, staff, and others involved with the system
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices
- Seeks to actively resist re-traumatization'

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific. The six key principles include:

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice and choice
- Cultural, historical, and gender issues

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services, and supports that are trauma-informed, build on the best evidence available and consumer and family engagement, empowerment, and collaboration."⁴⁸

Adverse Childhood Experience Study (ACES)

The landmark study was conducted by the Centers for Disease Control and Prevention and Kaiser Permanente between 1995 and 1997 in one of the largest investigations to assess the associations between childhood maltreatment and later-life health and well-being. More than 17,000 people received physical examinations and completed confidential surveys containing information about their childhood experiences and current health status and behaviors.

Definition

“Adverse childhood experiences (ACEs) are potentially traumatic events that can have negative, lasting effects on health and well-being.”⁴⁹ These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. “An Adverse Childhood Experience is defined as experiencing any of the following categories of abuse, neglect, or significant loss prior to age 18:

- Physical abuse by a parent
- Emotional abuse by a parent
- Sexual abuse by anyone
- Growing up with an alcohol and/or drug abuser in the household
- Experiencing the incarceration of a household member
- Living with a family member experiencing mental illness
- Domestic violence
- Loss of a parent
- Emotional neglect
- Physical neglect

The Impact of Adverse Childhood Events

- Increased risk for smoking, alcoholism, and drug abuse
- Increased risk for depression and suicide attempts
- Poor self-rated health
- 50 or more sexual partners
- Greater likelihood of sexually transmitted disease
- Challenges for physical inactivity and severe obesity
- Likelihood of attempted suicide the lifespan
- Increased risk for broken bones
- Heart, lung, and liver disease
- Multiple types of cancer”⁵⁰



Section 5:

Compliance with NWSDS Protocols and Rules of the Road



Section 5: Compliance with NWSDS Protocols and Rules of the Road

NWSDS Program Requirements

Confidentiality

“Confidentiality is the right of an individual to have personal, identifiable, medical information kept private.”⁵¹ The mentor is required to keep all mentee communication and information confidential. The exceptions to this rule is if someone communicates harm to self or others, or if someone is being abused and if a court or federal security entity orders the release of certain information about a mentee and there is a legal requirement to comply with this order. The only person who will have knowledge of your communication will be your immediate supervisor. Strict confidentiality is maintained for all mentee information and records. To keep confidential information private, follow these guidelines:

- Discussion regarding mentees will be held in locations that assure privacy.
- No privileged information about mentees or this agency will be discussed with family and/or friends.
- Mentee or volunteer information shared within the context of group meetings, clinical sessions, and educational seminars will be held in strict confidence.
- Violation of confidentiality rules will result in immediate separation from the volunteer program.
- The only individuals allowed access to such information are agency staff who have professional need for the information.
- No communication and/or records will be disclosed to anyone outside the relationship with your mentee without prior written consent from your mentee.

Mandatory Abuse Reporting

Senior Peer Mentors are considered agents of NorthWest Senior & Disability Service (NWSDS) and, therefore, are mandatory reporters under the following Oregon Administrative Rule. Under Oregon Administrative Rule 411-020-0002 (20), all employees [and volunteers] of Area Agencies on Aging (AAA), including NWSDS, are required to report suspected abuse of certain protected populations. Those protected populations include:

- Children under the age of 18
- Elderly, age 65 and over
- Adults with developmental disabilities
- Adults with mental illness
- Residents in nursing facilities, any age

Reportable abuse includes physical abuse, financial abuse, sexual abuse, neglect, abandonment and verbal or emotional abuse.

NWSDS volunteers who have become aware of the abuse of a child under the age of 18 are legally required to report that abuse to their local Child Welfare Office or local law enforcement agency, 24 hours a day, 7 days a week. NWSDS volunteers who become aware of abuse of a member of the other protected populations listed above are legally required

to report the abuse if they become aware of it while volunteering in their official capacity. Those reports may be made to either the local DHS or AAA office or to law enforcement. NWSDS volunteers who fail to report suspected abuse as required by law may face criminal or civil penalties for failure to report. A volunteer who is involved as the respondent in a charge or allegation of abuse must report it to the senior peer mentor program coordinator. Beyond the legal reporting requirements outlined above, NWSDS volunteers are encouraged to make voluntary reports of abuse of persons with physical disabilities who do not fall under one of the protected categories listed above, either to the local Department of Human Services or Area Agency on Aging office or to law enforcement.

Elder Abuse and Self-Neglect

In the United States, elder abuse and self-neglect have reached epidemic proportions. Each year more than 500,000 older adults are abused, neglected, and exploited by family members, friends, trusted others, and professional caregivers. In addition, thousands of older adults languish in self-neglect. “The National Center on Elder Abuse estimates that between two to five million older Americans suffer from some sort of elder abuse each year (including self-neglect).”⁵²



“In Oregon, the Office of Adult Abuse Prevention and Investigations Annual Report for 2013 wrote in their Executive Summary that county and local offices received over 35,000 reports of possible abuse or neglect of all vulnerable Oregonians. 16,500 allegations were assigned for investigation to determine if abuse, neglect or self-neglect had occurred. 8,016 of the allegations were for older adults and people with disabilities living in the community.

Of those 8,016, 2,025 adults were determined to have been abused. 3,625 allegations were for older adults and people with physical disabilities living in licensed facility settings. Of those 3,625 allegations, 544 adults were determined to have been abused”⁵³

These statistics underestimate the full extent of abuse because many victims may be reluctant to report abuse because of fear of retaliation, have the lack of physical and/or cognitive ability to report, or have an unwillingness to get an abuser in trouble (many are family members).

In general, elder abuse is defined as referring to “any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a

vulnerable adult. These laws vary from state to state, but abuse is defined as:

- Physical Abuse - Inflicting, or threatening to inflict, physical pain or injury on a vulnerable elder, or depriving them of a basic need.
- Emotional Abuse - Inflicting mental pain, anguish, or distress on an elder person through verbal or nonverbal acts.
- Sexual Abuse - Non-consensual sexual contact of any kind.
- Exploitation - Illegal taking, misuse, or concealment of funds, property, or assets of a vulnerable elder.
- Neglect - Refusal or failure by those responsible to provide food, shelter, health care or protection for a vulnerable elder.
- Self-Neglect - Characterized as the behavior of an elderly person that threatens his/her own health or safety and generally manifests itself by failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions.
- Abandonment - The desertion of a vulnerable elder by anyone who has assumed the responsibility for care or custody of that person.

Elder abuse can affect people of all ethnic backgrounds and social status and can affect both men and women.”⁵⁴

If you know or suspect a person living in a long-term care facility is being subjected to abuse or neglect, as a mandatory reporter you are required to act. In addition to reporting to the ombudsman in the facility, you must report to either the Adult Protective Services Unit for your local Area Agency on Agency or local law enforcement. The toll-free number for the Oregon Department of Human Services is 1-855-503-SAFE (7233).

Health Insurance Portability & Accountability Act (HIPAA)

The HIPAA Act passed in 1996 was designed to improve efficiency and effectiveness of healthcare systems and protect the privacy of patient medical records and other health information.

What is HIPPA?

HIPAA is the federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance and protect the confidentiality and security of healthcare information.

HIPAA provides for the protection of individually identifiable health information that is transmitted or maintained in any form or medium. The privacy rules affect the day-to-day business operations of all organizations that provide medical care and maintain personal health information.



What Health Information is Protected?

“HIPAA protects an individual’s health information and their demographic information. This is called ‘protected health information’ or ‘PHI.’ Information meets the definition of PHI if, even without the patient’s name, if you look at certain information and you can tell who the person is then it is PHI. The PHI can relate to past, present or future physical or mental health of the individual. PHI describes a disease, diagnosis, procedure, prognosis, or condition of the individual and can exist in any medium – files, voice mail, email, fax, or verbal communications. HIPAA defines information as protected health information if it contains the following information about the patient, the patient’s household members, or the patient’s employers:

- Names
- Dates relating to a patient , i.e. birthdates, dates of medical treatment, admission and discharge dates, and dates of death
- Telephone numbers, addresses (including city, county, or zip code) fax numbers and other contact information
- Social Security numbers
- Medical records numbers
- Photographs
- Finger and voice prints
- Any other unique identifying number”⁵⁵

Definition of HIPAA

“Protected Health Information (PHI) is any information about health status, provision of health care, or payment for health care that can be linked to a specific individual. This is interpreted rather broadly and includes any part of a patient's medical record or payment history.”⁵⁶ All senior peer mentors will be given and required to use a secure transportation bag to transport all PHI throughout the duration of their volunteer experience.

Secure Bags

Due to the sensitivity of the information regarding mentees, peer mentors will be provided with a secure transportation bag in order to ensure that all confidential information will be protected during transportation of protected health information.

Informed Consent

“Informed consent is a process for getting permission before conducting a healthcare intervention [service] on a person. A health care provider may ask a patient to consent to receive therapy before providing it, or a clinical researcher may ask a research participant before enrolling that person into a clinical trial. Informed consent is collected according to guidelines from the fields of medical ethics and research ethics.

An informed consent can be said to have been given based upon a clear appreciation and understanding of the facts, implications, and consequences of an action. To give informed consent, the individual concerned must have adequate reasoning faculties and be in

possession of all relevant facts. Impairments to reasoning and judgment that may prevent informed consent include basic intellectual or emotional immaturity, high levels of stress such as PTSD or a severe intellectual disability, severe mental illness, intoxication, severe sleep deprivation, Alzheimer's disease, or being in a coma.



Some acts can take place because of a lack of informed consent. In cases where an individual is considered unable to give informed consent, another person is generally authorized to give consent on his behalf, e.g., parents or legal guardians of a child (though in this circumstance the child may be required to provide informed assent) and conservators for the mentally ill.”⁵⁷

During the first visit, we will collect the mentee’s informed consent about our purpose for meeting with them.

Transportation of Mentees

Transportation is a significant need among older adults in our communities. Oftentimes, older adults are looking for transportation to and from doctor appointments, to the grocery store, and to pick up medications. As peer mentors, transportation is not an option. Under no circumstances should a peer mentor transport a mentee. If transportation is needed by the mentee, the peer mentor will assist in locating appropriate public or private transportation.

Email, Electronic Communication, and Texting

All communication using these methods must be protected. Northwest Senior and Disability Services has a secure emailing system that is to be used when communicating protected health information. Texting is also not protected and therefore should not be used with mentees or about mentees in any manner.

Gift Giving and Receiving

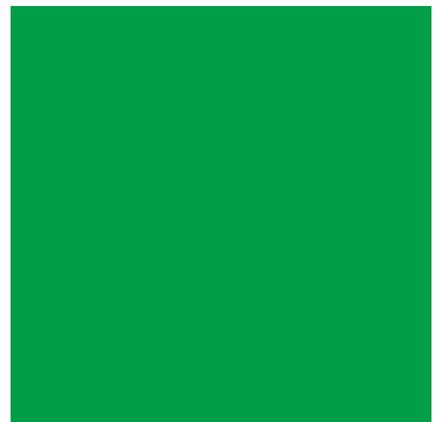
Due to the nature of the relationship, it will be important for the mentors to refrain from giving and receiving gifts from all mentees. It is important to keep this relationship as a mentor/mentee relationship and maintain healthy boundaries.

Guarding Your Safety

The mentors should maintain their safety in all situations. If at any time, the mentor feels uncomfortable with any situation they are required to use their best judgement to get out of the situation. If the mentor has any reservation about entering a home, they should decline.

Section 6:

Organizing Visits, Using the Workbooks, and Self-Care



Section 6: Organizing Visits, Using the Workbooks, and Self-Care

The Process—Connecting the Mentee to a Mentor

Anyone can make a referral to the HOPE Peer Mentoring Program. This includes family members, hospital discharge planners, psychiatrists, psychologist, home-health agencies, case managers, therapists, community members, and the individual themselves. Many individuals are referred to the program to address:

- Depression
- Anxiety
- Grief and loss experiences
- Loneliness
- Isolation
- Family difficulties
- Difficulty adjusting to a new living situation
- Lack of natural supports

Screening

After a referral is made, the mentee will go through an initial screening process and the peer Mentor coordinator or identified screener will determine appropriateness for the HOPE Program. The screening will include:

- An overview of the program
- Discussion of the workbooks
- Administration of the instruments (PHQ-9, GAD-7)
- Consent to participate in the program
- Timeline for when contact will be made by assigned mentor

If the individual is not appropriate for peer mentoring services, they will be connected to community partners that may better meet their needs. If an individual appears to need professional therapeutic services, they will be given resources and assistance to get connected with services or will utilize mental health crisis services. The screener will also follow the safety protocol that directly correlates with the final score on the instruments (PHQ-9, GAD-7).

Assignment to a Mentor

When mentees are assigned to a mentor, there are several things to consider:

- Personalities types
- Location
- Availability for Mentor
- Compatibility
- Life experiences
- Cultural differences
- Common interests

Getting Started with a Mentee

Within three days of being assigned a mentee, the mentor will make telephone contact to schedule the first visit at a mutually agreeable day and time. Identify yourself as a Senior Peer Mentor, identify the person who made the referral, and express appreciation of the mentee's willingness to meet. Be sure to log your call on the progress note. The initial telephone contact is most critical to the success of your ongoing relationship. You can also use appointment cards for subsequent visit reminders. The mentor will want to explain a bit about the HOPE Program.



For example, discuss the:

- Goals of the program
- Expectations of a peer mentor
- Expectations of the mentee
- Importance of open communication between the mentee and mentor
- Basic format of the visits, including a brief introduction of the workbooks
- Offer your business card to the mentee and explain whether the mentee can access you by personal email and/or telephone (and, if so, any restrictions) or by leaving messages on Program Coordinator's email or telephone voice mail.

Due to HIPAA regulations, if there is no answer, do not leave a message. If another person answers, simply thank the person and call back at another time. If, after multiple attempts, you cannot make a personal connection, please contact the program coordinator.

Managing the Paperwork

Mentee Folders

When the mentor is assigned to a mentee, they will receive a mentee folder with materials to assist and support the mentor with all required paperwork and the structure of each visit. These mentee folders will be a visual reminder as to what paperwork needs to be completed throughout your work with each mentee. You will receive a new mentee folder each time you are assigned a new mentee.

Mentor Adherence Checklist

On the left side of the mentee folder, you will find the Mentor Adherence Checklist. The purpose of the checklist is to guide the mentor through each session. You will notice that there are 10 sheets of paper stapled to the left side of the folder. If you look at the top of

each sheet, you will notice the visit number. The first page is for Visit 1 and is to be completed throughout your first visit with the mentee. The rest of the pages will be completed with the corresponding visits (For example: On your 7th visit, you will complete the Mentor Adherence Checklist – Visit 7).

Other Materials

On the right side of your mentee folder, you will find several items, including:

- Referral form – This is for the mentor’s information and communicates who made the referral and the reason for the referral.
- Completed instruments (PHQ-9 and GAD-7) – At the screening, the mentee will complete both instruments and the mentor will use them to set mentee goals.
- HOPE Senior Peer Mentor Program Welcome Letter – This will be given to the mentee.
- Crisis Contact Numbers – This will be given to the mentee.
- Initial Contact Form – This is to be completed by the mentor after the first visit.
- Mentee Progress Monitoring Sheet – The mentor completes this after each visit.
- Post-test Instruments – To be completed by the mentee during the last visit and collected by the mentor, then returned to program coordinator.
- HOPE Senior Peer Mentor Closing Letter – This will be given to the mentee.
- Final Contact Form – This is to be complete after your last session.

As you work through the mentee folder, you will be completing forms during and/or after visits. The goal is to have the forms completed and turned in once a month. These forms are either mailed, given to the program coordinator, or dropped off at any NWSDS office.

Writing Narrative Notes

There are many reasons to document a narrative note for each contact. Here are a few reasons:

- Document mentee needs
- Keep track of changes in mentee’s status
- Track mentee progress
- Refresh your memory
- Document the mentee’s journey
- Include a chronology of your contact with the mentee
- Meet a requirement of our grant funding source

Things to Avoid in the Narrative Note

- Personal feelings or judgments about the mentee
- Speculation
- Information about individuals not directly involved in the mentee’s services
- Information or events not relevant to the mentee’s progress

Self-Guided Workbooks

The Senior Peer Mentor Program uses a series of workbooks with mentees to help to educate them and guide further discussion about anxiety or depression in older adults. The workbooks follow a cognitive behavior therapy model (CBT). Chris Williams, author of the *Overcoming Depression and Low Mood* and *Overcoming Anxiety, Stress and Panic*, mentions that people using the depression and anxiety workbooks felt less depressed and less anxious and were more able to live their lives as they wanted. There is abundant research that demonstrates the efficacy of self-guided CBT workbooks in the reduction of depression and/or anxiety in older adults.

Introducing CBT Workbooks to the Mentee

When you introduce the self-guided workbooks to the mentee, it is important you communicate an openness and honesty about the use of the materials. Even though the mentee may be open to the idea of self-guided support, there may be some lingering reluctance to getting started with the workbooks. Self-guided workbooks may be a new concept and the mentee may take some time to adjust to this idea. The following are some suggestions about what you might say:

- “As part of this program, workbooks are provided to ensure that you can work independently as well as with the mentor on your goals.”
- “Workbooks are provided to help you move toward recovery.”
- Let’s decide together what you would like you to work on.”
- “After getting acquainted, we can choose what workbooks will be most useful to you.”

With the self-guided workbooks, some of the benefits for the mentees are:

- Easy access to self-help material
- The mentee’s option to read the workbooks independently, in private, without scrutiny
- The availability to read the workbooks whenever they like
- The ability for the mentee to refer back to the information when needed
- The mentee’s opportunity work on the material in any location
- The mentee’s ability to work at their own pace

You and your mentee will work together to identify the workbooks and sequence for use of these workbooks. Each workbook is designed to require approximately a week or so of mentee time to accomplish the material. However, the timelines for completion and sequencing are highly individualistic.

The mentor will offer the first depression or anxiety workbook to the mentee and will talk about the effectiveness and benefits of the self-guided workbook program. Begin working through the first workbook with the mentee and talk about a goal for the next visit. If the mentee hesitates or declines to continue, try to draw out the mentee’s hesitations.

Negotiate an agreement to at least begin the independent work of using the first workbook before your next visit by obtaining a commitment of having the mentee read at least five or six pages.

Compassion, Compassion Fatigue, and Burnout: Working Definitions

- Compassion literally means “to suffer with,” also referred to as a “soul sadness;” feeling a great sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain and remove the cause.
- Compassion fatigue is referred to as secondary traumatic stress, secondary victimization, and secondary survivor syndrome; refers to a physical and spiritual fatigue or exhaustion that takes over a person.
- Burnout is a feeling of hopelessness and difficulties in dealing with work or in doing your work effectively (these negative feelings usually have a gradual onset); frequently, burnout is a precursor of compassion fatigue.

Caring for and about others is very rewarding but can also come at a price. Helping yourself first means you can better help others. When we want to help others, taking care of ourselves first makes us more effective helpers. It is important to acknowledge that taking moments for yourself is not selfish but is, instead, a vital part of effective helping. Being purposeful about taking care of yourself gives you an opportunity to recall the joy in serving others. Self-care is different for each person. Each person must be consciously aware of the need for self-care and choose a strategy that suits himself or herself best.

Self-Care Strategies

It is important to make certain you are not harmed by your volunteer relationships. You must recognize your own vulnerabilities and how you could be placing yourself at risk. In general, remember to:

- Be gentle with yourself.
 - * Let go of idealism.
 - * Allow yourself the same gift of compassion you extend to others.
 - * Take your efforts in stride. You are only one person, caring and capable, doing your best for people who are in need.
 - * Identify a portion of your life when you are able to take rather than give.
 - * Create balance in your own life.
 - * Keep things in perspective.
 - * Keep in mind that you are not responsible for others’ choices.
 - * Do not take things personally.
- Engage in various activities.
 - * This does not have to be your only interest.
 - * If you need a break from volunteering, take one.



- Seek renewal.
 - * Renew your feelings of hope.
 - * Find meaning in your volunteering.
 - * Identify what is important to you and live a way that reflects it.
- Identify and celebrate success with your mentees.
 - * Commit to self-compassion.
 - * Practice mindfulness.
- Cultivate your nourishing relationships.
 - * Talk to someone who knows more than you do or who shares your challenges.

Closing the Mentoring Relationship

The end of services will be decided at Supervision prior to talking to the mentee about the final session. The close of the mentoring relationship will likely produce a number of emotions for both the mentee and for the mentor. The following are some ways to maximize a positive reaction from the mentee when the relationship ends:

- Avoid making the relationship the central feature of your helping by focusing on the mentee seeing how their actions will lead to success.
- Discuss their accomplishments and the value of independence.
- Encourage the mentee to use all new skills

The traditional number of visits will be a function of how many workbooks you suggest for the mentee and the time a mentee takes to process each workbook. When closing the relationship, end the visits on a high note by:

- Talking about all of the mentee's accomplishments (however big or small)
- Discussing the goals that have been completed
- Making connections with natural supports
- Providing crisis numbers and contact information for the agency
- Celebrate their recovery



Testimonials of Senior Peer Mentors

“I do believe this program is so good for so many in our community and I will continue to work hard so the program continues and we as mentors continue to help others.

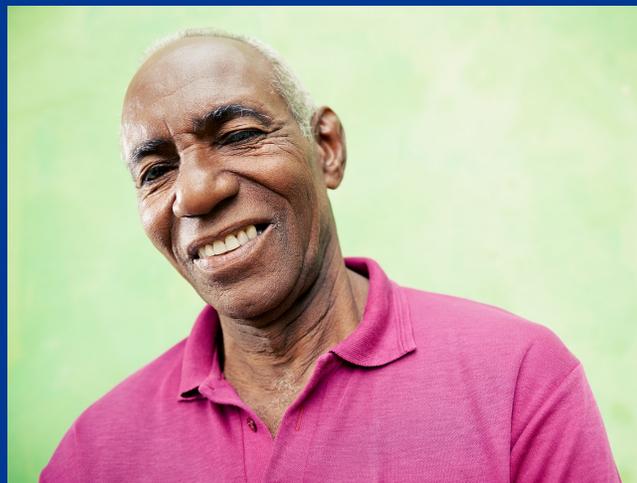
Reviewing my time spent with mentees is so positive and reminds me that I, too, get a lot from this program.”

—Jan



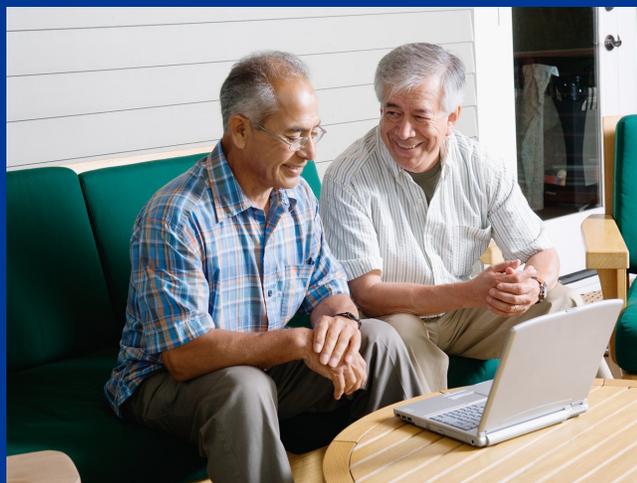
“In the program, I have always felt I received far more than I have given. As a mentor, one does not give advice as much as one listens, shares experiences, gains insights, and re-directs in the process. Sharing insights and ideas with other volunteers in small groups is a wonder way to make new friends. At the age in our life’s journey when many of our peers are becoming sedentary, this program offers an opportunity to continue to give and grow.”

—Claudie



“One remark often heard in the military is “don’t volunteer for anything.” Later in life you may discover that volunteering adds a dimension to your life that you didn’t expect. I did! Volunteering presents opportunities you may never have thought about such as meeting people, learning new or different skills, expanding your knowledge of community needs, and making a difference. I chose volunteering as a Senior Peer Mentor as my passion. Committing time to this program benefited me more than all the years in my formal work environment.”

—Jim



“Becoming a Senior Peer Mentor is not only rewarding; it stretches you own sense of self. It has taken me out of my comfort zone, taught me how to empathize, and given me a sense of accomplishment. Each mentee has, in a sense, helped me with other mentees. For me, this experience has had an “ah-ha” effect not only for me, but for most of my mentees.”

—Joanna



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