Reclaiming Joy: Pilot Evaluation of a Mental Health Peer Support Program for Older Adults Who Receive Medicaid

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Purpose: Stigma and lack of access to providers create barriers to mental health treatment for older adults living in the community. In order to address these barriers, we developed and evaluated a peer support intervention for older adults receiving Medicaid services. Design and Methods: Reclaiming Joy is a mental health intervention that pairs an older adult volunteer with a participant (older adult who receives peer support). Volunteers receive training on the strengths-based approach, mental health and aging, goal setting and attainment, community resources, and safety. Participant–volunteer pairs meet once a week for 10 weeks. Participants establish and work toward goals (e.g., better self-care, social engagement) that they feel would improve their mental health and well-being. Aging services agencies provide a part time person to manage the program, match volunteers and participants, and provide ongoing support. Outcomes evaluation for this pilot study included pre/postintervention assessments of participants. Results: Thirty-two participants completed the intervention. Pre/postassessments showed statistically significant improvement for depression but not for symptoms of anxiety. Quality-of-life indicators for health and functioning also improved for participants with symptoms of both depression and anxiety. Implications: The Reclaiming Joy peer support intervention has potential for reducing depression and increasing quality of life in low-income older adults who have physical health conditions. It is feasible to administer and sustain the intervention through collaborative efforts with minimal program resources and a small amount of technical assistance.

Key Words: Mental health (services, therapy), Peer support, Strengths based, Outcomes evaluation, Medicaid/Medicare
Depressive symptoms affect more than 5 million adults aged 65 and older nationally (National Institute of Mental Health [NIMH], 2010). Further, 20% of older adults living in the community may be experiencing mental health problems (Adamek & Slater, 2008). Yet, it is estimated that almost half of older adults with a recognized mental health disorder do not seek or receive mental health services (Bartels et al., 2002). There is evidence that depressive disorders, including subsyndromal depression, can exacerbate effects of diseases such as cardiac disease and diabetes (Lyness et al., 2007). Recent research indicates that individuals with depression and chronic disease have significantly higher total health care costs than those with chronic disease but no depression (Unützer et al., 2009). Further, limited access to mental health services for older Americans increases the risk for premature placement in nursing facilities (U.S. Department of Health and Human Services [DHHS], 1999). Conversely, research has also shown that reducing mental illness can improve older adults’ physical health (Ormel et al., 1993).

Many older adults know little about depression and believe it is “normal” for people to get depressed as they grow older (U.S. DHHS, 1999). However, older adults respond well to interventions for depression and other mental illnesses when they do receive help (Karel & Hinrichsen, 2000). Unfortunately, limited knowledge, stigma, and lack of access to providers create barriers to treatment for this underserved population. To overcome these barriers, alternative services to address mental health concerns in older adults are needed.

Strategies identified as effective in addressing mental health needs of older adults often include the use of interdisciplinary geriatric teams made up of mental health, primary care, and rehabilitation specialists working together to integrate care (e.g., Cummings, 2009; Emery, Lapido, Eisenstein, Ivan, & Golden, 2012). Unfortunately, many older adults live in rural counties where even primary care physicians are in short supply. Other strategies include a statewide policy approach requiring mental health centers to have an aging specialist on staff. However, scarcity of trained geriatric professionals makes it difficult to recruit aging specialists. Increasing access by bringing services into the home is yet another challenge (Johnston et al., 2010).

Faced with these realities, service providers and university investigators worked collaboratively with the state department on aging to develop, implement, and evaluate a peer support approach to address symptoms of depression and anxiety. Reclaiming Joy is designed for older adults with symptoms of depression or anxiety and functional limitations due to physical health diagnoses. In this article, we first describe the Reclaiming Joy intervention. We then present results from our pilot study with community-dwelling older adults with low incomes and conclude with implications for practice and research.

**Previous Research**

Peer provided mental health support contributes to a positive social context that is necessary for recovering from mental health issues (Briscoe, Orwin, Ashton, & Burdett, 2005). The mental health literature and government programs such as Medicaid support the use of peer interventions for adults with mental health diagnoses, including severe mental illness (e.g., Bazelon Center for Mental Health Law, 2003; Solomon, 2004). The unique quality of peer–consumer relationships is distinct from that of professional–client relationships (Salzer & Shear, 2002). Unique benefits of peer relationships include expansion of social networks, empowerment, self-determination, and reduction of stigma through role modeling, empathetic understanding of strengths, and making sense of their experiences (Davidson et al., 1999; Solomon, 2004). Consumer benefits also include lowered mental health symptoms, higher satisfaction with services, and feelings of greater autonomy (Campbell & Leaver, 2003).

However, there are less data on the efficacy of peer support programs for older adults, and most studies report results from measures of customer satisfaction (e.g., Haber, 2003). Friendly visitor programs for older adults are found to be effective and address social isolation that can lead to symptoms of depression. However, the main purpose of these programs is to provide companionship and assistance with daily tasks such as grocery shopping and transportation (Butler, 2006). In contrast, our peer support approach not only provides social contact but also is guided by the goal-setting process and builds skills and connections to the community.

**Theoretical Underpinnings**

This intervention was guided by principles of community engagement in research, the strengths
approach, and ecological models. The intervention evolved based on input from service providers, policymakers, and older adults. Policymakers were interested in potential cost savings associated with reductions in health care utilization stemming from improved mental health, and older adults wanted home-based services. Using values and strategies of community engagement in research, we developed strong partnerships with the Area Agencies on Aging (AAAs) in which we shared project responsibilities, resources, and funding and worked to build capacity and sustainable relationships (Ahmed & Palermo, 2010).

The strengths perspective posits that goals, strengths, and human and environmental resources, rather than their problems and pathologies, should be the central focus of the helping process (Saleebey, 1992). Accordingly, strengths-based interventions focus on abilities of individuals and their social support network and include strategies that build on individuals’ strengths and successes (Brun & Rapp, 2001; Nelson-Becker, Chapin, & Fast, 2009). Strengths-based models of case management have been used by social service providers for older adults and for persons with mental illness; positive outcomes have been documented for both (Fast & Chapin, 2000; Rapp & Goscha, 2006). Thus, development of the intervention was guided by strengths-based principles by incorporating a strengths inventory, goal setting, empowerment, assertive outreach, and connection to both formal and informal community resources into the intervention.

Ecological models (e.g., Bronfenbrenner, 1979; Germain & Gitterman, 1996) in the context of healthy aging focus on linkages between multiple levels of older adults’ environments and health outcomes (Hudson, 2010). Ecological approaches have been used within gerontology in regards to health, mobility limitation, mental health, and late-life transitions (e.g., Chapin et al., 2010; Greenfield, 2012). We designed Reclaiming Joy as a multilevel intervention to influence disease processes and health, which worked to address interpersonal and environmental factors influencing health through goal setting and assertive engagement of community resources.

Overall, we worked to develop an intervention that could be offered in a setting chosen by service recipients (e.g., at home) and administered at low cost through AAAs and other community agencies. We also wanted to carefully evaluate the intervention to determine its potential to become an evidence-based practice that can be implemented nationwide. Our intent behind the intervention was to utilize the dyadic relationship between volunteers and participants to guide participants through goal setting and assertively foster connections to community resources. We encouraged volunteers to work with participants to increase participation in informal activities that support mental health and expand social networks so that social isolation does not reoccur following the intervention.

Hypotheses used in the evaluation of the pilot data included the following: (a) the intervention will be feasible to implement and sustain and (b) following participation in the initiative, older adults will experience reduced symptoms of depression and anxiety, increased quality of life, and reduced health care utilization. This article focuses on hypotheses testing of relationships between the intervention and reduced symptoms for depression, anxiety, and increased quality of life.

Methods

Intervention

Participants and Volunteers.—The most salient feature of the intervention was pairing an older adult “participant” experiencing mental health symptoms with an older adult peer “volunteer” who then met once a week for 10 weeks. Additional program activities included identifying personnel to recruit and screen volunteers and participants, training volunteers, making a “match,” and providing ongoing support for volunteers. Volunteers and participants were recruited by community presentations, flyers, word of mouth, and referrals from aging service agencies. Participants and volunteers were screened per a recommended protocol. For participants, this included mental health screening. As appropriate, older adults were referred to mental health and other formal services.

A 2-hr training session for volunteers included information on mental health and aging, the strengths-based approach, goal attainment skills (e.g., goal setting, reframing), community resources, and the volunteer role. Training also addressed safety issues such as handling a health crisis and recognizing signs of abuse. Additionally, we provided the volunteers with training supplements that included handouts with information covering each major topic, resource guides tailored to their area, and contact information for relevant research and AAA staff. Further, a comprehensive training
manual and DVD were also supplied to AAA staff who were available to provide ongoing guidance as requested by volunteers.

Program personnel paired participants with volunteers on the basis of gender, geographic location, and similar interests that were identified during the screening process. A history of mental health issues or treatment was not required to be a volunteer, volunteers were unpaid, and a criminal background check was performed during the pilot study. Prior to the initial meeting between volunteer and participant, program personnel shared pertinent, but anonymous, information with the volunteer. If the volunteer agreed to the match, information was shared about the volunteer with the participant who then had the choice to accept or decline. Both parties made a commitment to meet, in person for at least an hour once a week for 10 weeks.

**Ten-Week Intervention.**—The content and time frame of the intervention were, in part, guided by our knowledge of brief treatment interventions, such as task-centered and solutions-focused approaches. These approaches are often time limited to less than 10 sessions and are proven to be effective in improving mental health conditions in older adult populations (Gingerich & Eisengart, 2004; Naleppa & Reid, 2000). Therefore, we structured the intervention to be task centered and 10 weeks long to create a clear focus for the participants’ and volunteers’ time together.

The face-to-face meetings and goal-setting component were key to the intervention. Regular meetings in the participant’s home provided needed social contact integral to the lessening of depressive symptoms (Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006; Cornwell & Waite, 2009). However, the strengths-based goal setting provided a framework for the participant to discover strengths and resources to improve well-being. The heart of the intervention was engagement with community resources and activities guided by the goal-setting process to provide skills and connections to the community that would last long past the 10-week intervention.

Once the match was made, program personnel arranged the initial meeting. The volunteer could go on the first visit alone, if both parties were comfortable. One of the participant and volunteer’s first tasks was to complete a brief strengths inventory (Nelson-Becker, Chapin, & Fast, 2009). During the intervention period, the pair established and worked toward participant-generated goals to improve their mental health and well-being (e.g., better self-care, engaging with family and friends). Volunteers used information from the brief strengths assessment to support participants by exploring resources, developing problem-solving skills, and creating action steps to meet goals. Most matches ran smoothly without encountering any problems. However, volunteers were asked to contact program personnel every 2–3 weeks with a brief update. Program personnel provided support as needed, plus tracked progress of the intervention.

**Sample**

The pilot study took place at three intervention sites. The purposive sample of Reclaiming Joy participants included adults aged 64 and older who were receiving Medicaid in three AAA service regions in a Midwest state. Two of the regions include counties considered semi-urban and urban, and the third region contains rural, densely settled rural, and semi-urban counties (Kansas Department of Health and Environment, 2012). To ensure fidelity to the intervention across research sites, investigators made presentations to case managers and other agency staff, so all sites had a common understanding of the Reclaiming Joy model and staff could recruit participants. Research team members trained to increase reliability conducted intake and other assessments.

AAA case managers identified potential participants from their caseload based on their clinical expertise. Clients who exhibited symptoms of depression or anxiety were provided program information and asked if they wanted to participate in the study by case managers. If clients expressed interest in participation, case managers referred them to research staff who determined eligibility. Primary eligibility criteria were Medicaid enrollment, to control for income level and access to Medicaid services, and the presence of at least one symptom of depression and/or anxiety assessed during intake using standardized measures. For participant/volunteer safety and research integrity, eligibility guidelines contained several exclusionary criteria, including the presence of exploitation or abuse, abuse of alcohol or illicit substances, a guardian or conservator, an inability to speak/write English, or a Mini-Mental State Examination (MMSE) score of more than 16 (Folstein, Folstein, & McHugh,
If the older adult had received mental health services or taken psychotropic medications within the past 3 months, had a current or past diagnosis of psychosis, or past history of suicide attempts/plans, eligibility was determined on a case-by-case basis in consultation with case managers and the research team. Protocols ensured that any older adult in a risk situation (e.g., exploitation) received appropriate assistance.

Ninety potential participants were approached regarding the program; 21 declined and 16 did not meet eligibility criteria. Ultimately, 53 individuals both expressed interest in the pilot intervention and met eligibility criteria and 40 (75%) were matched with a peer volunteer. Of those matched, 32 participants completed the intervention. Those who did not complete the intervention did not differ significantly by age or scores on standardized assessments for depression, quality of life, or anxiety. The most common reason for not being matched or completing the intervention was incapacity due to deteriorating health of the participant.

All procedures for our research were approved by the Human Subjects Committee at the Primary Investigator’s university. We obtained informed consent, and interviewees were offered $10 per interview to compensate them for their time.

**Measures**

We collected data from participants’ preintervention and again 1 week postintervention. During intake, research staff conducted structured interviews to determine program eligibility and collected basic demographic information, as well as information on general health status, services received, health care utilization, recent nursing facility admissions, and social contacts.

Intake and postintervention assessments also included standardized tools administered by research staff who were master’s level social workers to measure participants’ change in depression (Geriatric Depression Scale [GDS-15]), anxiety (Beck Anxiety Inventory [BAI]), and quality of life (Ferrans and Powers Quality of Life Index [QLI]). The GDS-15 is able to detect longitudinal changes in depressive symptoms and has been found to have acceptable internal consistency reliability ($\alpha = 0.75$; Friedman, Heisel, & Delavan, 2005). Scores range from 0 to 15 (12–15 = severe, 9–11 = moderate, 5–8 = mild, and 0–4 = normal; Vinkers, Gussekloo, Stek, Westendorp, & Van Der Mast, 2004). BAI scores range from 0 to 63 (26–63 = severe, 16–25 = moderate, 8–15 = mild, and 0–7 = minimal), and the BAI has shown high internal consistency reliability ($\alpha = 0.92$; Beck, Epstein, Brown, & Steer, 1988). QLI scores, ranging from 0 to 30, include an overall quality of life total, as well as subscale scores for health and functioning, social and economic, psychological/spiritual, and family and are calculated using a scoring algorithm recommended by the authors. Internal consistency reliability for the QLI total score ($\alpha = 0.93$) and the four subscales ($\alpha = 0.87, 0.82, 0.90$, and 0.77) have been found to range from acceptable to high (Ferrans & Powers, 1992).

Additional data were collected at 90-day postintervention to determine changes in health care utilization. We also interviewed case managers about the influence of peer support on their clients. Preliminary findings emanating from these last two research components are briefly discussed later. Detailed results will be reported in subsequent articles.

**Data Analysis**

Quantitative analysis included descriptive analysis of demographic data and Likert-scale items. To assess change in participants’ pre- to post-test scores for depression, quality of life, and anxiety, we conducted paired sample $t$-tests.

**Results**

Table 1 highlights demographic characteristics of the 32 participants and 30 volunteers who completed the intervention during the pilot study. The mean age for participants was 76 years, with a range of 64–87 years. Most participants were Caucasian and were women; most (75%) had at least some high school education. The majority of participants lived alone. Just over half of participants (58%) reported that they needed assistance with personal care needs (e.g., eating, bathing, dressing), and nearly all participants (95%) reported that they needed assistance with routine needs (e.g., household chores, shopping). Although funding did not allow for collection of data on the volunteer experience, volunteers did provide basic demographic information during intake assessment (see Table 1).

Participants’ symptoms of depression decreased following participation in Reclaiming Joy (see Table 2). As a group, participants’ mean GDS-15 score was 5.77 before the intervention, ranging
from 0 to 13 (normal to severe). In some cases, clinical interviews by researchers and case managers identified additional and more severe signs of depression. Therefore, depression experienced by some participants may be higher than what is reflected in the mean score of the GDS-15. GDS-15 mean scores improved 1.74 points to 4.03 following the Reclaiming Joy intervention ($p < .01$).

Results from participants’ quality-of-life scores were mixed. Pre- and postintervention scores improved significantly for the health and functioning subscale of the QLI. The mean health and functioning score at pre-test was 16.61, improving 2.81 points to a mean of 19.42 ($p < .01$). Individually, 21 out of 30 (70%) participants improved their QLI total score. However, mean differences were not statistically significant ($p = .070$). Differences in pre- to post-test mean scores for the other QLI subscales were also not statistically significant. Thus, participation in Reclaiming Joy was associated with increases in quality of life through improvements in health and functioning indicators.

BAI scores did not improve to the level of statistical significance ($p = .26$). However, it is important to note that 74% of participants with anxiety did show improvements in their quality of life.

**Discussion**

This pilot study demonstrated promising clinical outcomes and improvements in older adults’ quality of life. Participants showed statistically significant improvement in symptoms of depression after completing the intervention. Their scores also indicated positive change in health and functioning as measured by the QLI. Results related to reduction in anxiety were not statistically significant, indicating that participants showed improvements in their quality of life.

**Table 1. Demographic Characteristics of the Sample**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Participants (N = 32; % or mean)</th>
<th>Volunteers (N = 30; % or mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location 1a</td>
<td>69%</td>
<td>67%</td>
</tr>
<tr>
<td>Location 2</td>
<td>22%</td>
<td>23%</td>
</tr>
<tr>
<td>Location 3</td>
<td>9%</td>
<td>3%</td>
</tr>
<tr>
<td>Population density</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>84%</td>
<td>90%</td>
</tr>
<tr>
<td>Semi-urban</td>
<td>13%</td>
<td>7%</td>
</tr>
<tr>
<td>Densely settled rural</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Age (range of participants = 64–87; volunteers = 56–80)</td>
<td>76 years</td>
<td>67 years</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>78%</td>
<td>80%</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>97%</td>
<td>83%</td>
</tr>
<tr>
<td>African American/American Indian/Alaskan Nativeb</td>
<td>3%</td>
<td>17%</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>97%</td>
<td>57%</td>
</tr>
<tr>
<td>Residential location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single family dwelling or apartment</td>
<td>82%</td>
<td>97%</td>
</tr>
<tr>
<td>Assisted living</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>75%</td>
<td>60%c</td>
</tr>
<tr>
<td>Enrolled in Medicaid</td>
<td>100%</td>
<td>Unknown</td>
</tr>
<tr>
<td>Assistance with personal care needs</td>
<td>58%</td>
<td>Unknown</td>
</tr>
<tr>
<td>Assistance with routine needs</td>
<td>95%</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

Notes. aMost participants who completed the program lived in the Location 1 catchment area due to the length of time the pilot was implemented in this area compared with the other research sites.

bAfrican American and American Indian/Alaskan Native categories were grouped together to protect confidentiality. No participants were Hispanic.

cMissing = 1.

dTwo of the volunteers was matched with two different participants during the pilot study.

**Table 2. Pre- and Postintervention Scores for Depression, Anxiety, and Quality of Life**

<table>
<thead>
<tr>
<th>Measures</th>
<th>Preintervention (N = 32); Mean (SD)</th>
<th>Postintervention (N = 30); Mean (SD)</th>
<th>p value ($t$ test)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDS-15b</td>
<td>5.77 (3.49)</td>
<td>4.03 (3.48)</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>QLI totalc</td>
<td>19.64 (4.32)</td>
<td>20.74 (4.82)</td>
<td>.070</td>
</tr>
<tr>
<td>Health/function</td>
<td>16.61 (5.64)</td>
<td>19.42 (5.76)</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>Social/economic</td>
<td>21.72 (4.58)</td>
<td>21.84 (5.21)</td>
<td>.878</td>
</tr>
<tr>
<td>Psych/spiritual</td>
<td>21.46 (5.38)</td>
<td>21.92 (5.86)</td>
<td>.658</td>
</tr>
<tr>
<td>Family</td>
<td>20.52 (5.15)</td>
<td>20.52 (6.51)</td>
<td>.999</td>
</tr>
<tr>
<td>BAIb</td>
<td>12.60 (7.40)</td>
<td>11.27 (6.63)</td>
<td>.261</td>
</tr>
</tbody>
</table>

Notes. BAI = Beck Anxiety Inventory; GDS = Geriatric Depression Scale; QLI = Quality of Life Index.

aMissing = 2. (One participant died and one participant was hospitalized immediately following the intervention.)

bLower scores indicate improvement.

cHigher scores indicate improvement.
although many participants with anxiety symptoms did experience improvements in quality of life.

In follow-up qualitative interviews, case managers who worked with participants perceived that the intervention contributed to improved mental health and quality of life, which supports quantitative findings. Case managers went a step further and credited participation in Reclaiming Joy with improvements in older adults’ physical health and reductions in need for home- and community-based services, as well as fewer stays in hospitals and nursing facilities. These qualitative findings are especially helpful in understanding the influence of program participation because detecting statistically significant changes is difficult for those who report few symptoms of depression and/or anxiety on initial assessments but exhibit signs of mental health concerns that are evident to their case managers.

This pilot study was the first step in ongoing efforts to rigorously evaluate the Reclaiming Joy intervention. This intervention is especially important for older adults with physical health conditions that limit their ability to fully participate in social and community activities. Results showed that the intervention has potential for reducing depression and increasing health-related quality of life in low-income older adults who have physical health conditions. Additional research is needed to further understand results for those with anxiety. We also plan to examine impact of this intervention on volunteers.

Seven agencies statewide have implemented this model. Through collaborative efforts, agencies that implemented the Reclaiming Joy sustainability model demonstrated that it is feasible to implement and sustain the intervention with minimal program resources and a small amount of technical assistance. Considering the difficult financial climate that has coincided with the intervention development and implementation, this is a testament to the agencies’ confidence in the value and viability of the program for improving older adults’ mental health and quality of life.

Given the relationship between mental and physical health, we also believe that this intervention could potentially help reduce costly hospital stays and visits to physicians or emergency rooms. Therefore, we are interested in piloting and evaluating Reclaiming Joy as a supplement to depression care management, chronic disease self-management programs, and hospital discharge initiatives. The peer support offered through this intervention could both motivate and reinforce self-management and healthy lifestyle behaviors. In fact, this initiative is already being expanded into new settings, building on the extensive training materials we have developed, and technical support we provided.

Limitations

The scope of this pilot project did not allow us to randomly select or assign participants to treatment and control groups; thus, we cannot attribute change to specific intervention components or rule out other factors. Additional research with comparison groups is needed to isolate mechanisms, or combinations of mechanisms, that contributed to the outcomes reported here. For example, it would be important to determine how one’s level of loneliness or social isolation influences outcomes. Further, the relatively small sample size limited our ability to conduct more sophisticated analyses and potentially influenced nonsignificant results. Additional research is needed to understand if nonsignificant results were due to type II error. Although we did have some racial/ethnic diversity in our sample, the sample size did not permit tests of racial/ethnic differences, which would be an important consideration in future studies.

Conclusion

As the proportion of older adults in the community increases, the need for age-appropriate mental health services that bypass barriers posed by mental health stigma will also increase. Service systems must proactively devise strategies that can be implemented and sustained in both urban and rural areas. Reclaiming Joy helps surmount barriers that often stand in the way of older adults receiving mental health treatment by providing services in the home and, by using older adult volunteers, thus reducing barriers related to stigma and cost. As this intervention is expanded into additional areas, we expect positive outcomes will continue to accrue.

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