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ASPN

Adult Services Practice Notes

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by

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*The aspen is perhaps the world's
largest organism. Although some
aspen forests cover acres and seem to
be composed of individuals in all
stages of life, they share a common
root system.*

*ASPN: Adult Services
Practice Notes* is
dedicated to providing
information on excellent
family-centered social
work practice with adults
and their families.

Not Just Sad Depression and Older Adults

In everyday English, we often say that people are depressed if they are blue or apathetic or if we know they have experienced some sort of sad event—a death in the family or other loss. Generally, we believe that their mood will change in a short time, and in the meanwhile, they continue with their normal routine. This commonplace use of depression to mean ordinary, short-term reactions to the normal ups and downs of living, however, can make us less sensitive to “big D” Depression (Major Depressive Disorder), which is a psychiatric condition that affects between 5 and 9 percent of women and 2 to 3 percent of men in the population at any given time (Long 1996). It is a disease that is very treatable, whether with medication or psychotherapy or a combination of the two. In older people, however, it is often difficult to spot, confused with other conditions, or mistaken for “normal aging.” Although the treatments are just as effective for older people as for younger, helping older adults get appropriate treatment may be difficult for a variety of reasons. In this issue, we’ll have a look at Depression, who is at risk, what can be done, and how to help.

What the *DSM-IV-TR* Says

The *Diagnostic and Statistical Manual of the American Psychiatric Association* (4th edition, text revision [2000]; *DSM-IV-TR*, for short) is the standard used to diagnose psychiatric disorders. See the box on the next page for the criteria for Major Depressive Disorder. At first glance, you may wonder how this differs from what we commonly call depression. Intensity and duration are the keys. Although these symptoms only need to be present for 2 weeks for a mental health

What’s Going On Here?

Mrs. L.’s concerned neighbor called DSS, because Mrs. L. seemed disheveled and confused. Mrs. L.’s husband of 50 years died one year ago. She is taking medication for osteoporosis, arthritis, and hypertension. Mrs. L. speaks to her neighbor when she sees her, but they don’t visit much. Mrs. L. no longer drives, and she can only afford a cab about once a month. Mrs. L.’s daughter, Lu-Ann, brings her groceries two to three times a month, but they don’t get along well. You talk to Lu-Ann, who says that Mrs. L. often accuses her of not caring and often says, “You’ll miss me when I’m gone.” In the last month, these complaints have gotten more frequent, and Lu-Ann says Mrs. L. has had some fits of temper. Also, Mrs. L. seems to sleep all the time, but she rarely finishes the food her daughter brings. In a recent training, you learned about the Geriatric Depression Scale. Mrs. L. agrees to answer the questions, and her score is 10.

- ♦ **What do you think is going on?**
- ♦ **What should you do next?**

(See the suggestions on page 5.)

The *DSM-IV-TR* criteria for Major Depressive Disorder

The person has *either* of the following for two weeks:

- ◆ Sad mood
- ◆ Loss of pleasure

and 5 or more of the following symptoms:

- ◆ Weight loss (sometimes gain)
- ◆ Sleep changes
- ◆ Restlessness or sluggishness
- ◆ Feelings of worthlessness
- ◆ Trouble concentrating
- ◆ Fatigue or loss of energy
- ◆ Recurrent thoughts of death or suicide

practitioner to make a diagnosis, Long (1996) suggests that the average episode lasts about 9 months. He also comments that while sadness is a normal reaction to loss, Major Depression causes marked functional impairment with disabling physical and psychological symptoms.

Perhaps more important when we're considering older adults are the symptoms themselves. While the rates of Major Depression and the related condition, Dysthymia (similar symptoms, but fewer of them, over 2 years), among older adults in the community are about 5 percent, anywhere from 13 to 27 percent of older adults have depressive symptoms. (In long-term care facilities the rates are substantially higher for both.) For social workers who are concerned with how well their clients are functioning and the quality of their lives, perhaps the most important thing is to recognize situations that are associated with depression, watch for symptoms, and help clients seek treatment and maintain whatever therapy is prescribed.

Chicken and Egg

It is hard, and perhaps not very useful, to disentangle Depression or depressive symptoms from other conditions that are often found with them. Which is the cause, and which the consequence? According to the Surgeon General's report, 5 to 10 percent of older adults suffer from insomnia, and this is a major risk factor for Depression. Similarly, 10 to 20 percent of people who have lost a spouse "develop significant depression during the first year of bereavement." Finally, "even in the absence of a clear stroke, disorders that cause vascular damage, such as hypertension, coronary artery disease, and diabetes mellitus, may induce cerebral pathology that constitutes a vulnerability for depression" (Surgeon General, 2000).

Long (1996) provides a list of illnesses associated with depression, among which are many that afflict older people: some types of arthritis, cancer (especially pancreatic and other gastrointestinal cancers), cardiopulmonary diseases, dementias, parathyroid disorders, Parkinson's disease, pneumonia, rheumatoid arthritis, renal diseases, thyroid disease, and vitamin deficiencies (B¹², C, folate, niacin, and thiamine).

Long (1996) also provides a long list of medications that are also associated with Depression. Among them are antihypertensives (beta-blockers) and compounds used to treat cancers, but they also include ibuprofen, steroids, and several antibiotics. Although today's older people rarely take such "drugs of abuse" as cocaine, which is on the list, alcohol abuse is also associated with Depression. Adults over 60 who consume more than one standard drink a day for men and less than one for women may unknowingly be misusing alcohol and contributing to Depression or depressive symptoms.

How Is Depression Treated?

Medications

The Surgeon General's report outlines many of the pros and cons of the various medications used, noting that "there is consistent evidence that older patients, even the very old, respond to antidepressant medications"—between 60 and 80 percent of older adults who take them improve (Surgeon General 2000).

Briefly, the two most common categories given are tricyclic antidepressants (TCAs, including amitriptyline, clomipramine, desipramine, imipramine, nortriptyline) and the selective serotonin reuptake inhibitors (SSRIs, including fluoxetine, paroxetine, sertraline, and citalopram). Monoamine oxidase inhibitors are prescribed for younger people, but not so often for older people.

One of the principal difficulties for older clients in using these drugs is finding one that is effective, yet has the least unpleasant side effects and the least likelihood of adverse reactions with other medications the client is taking. The Sur-

Screening Tools for Depression

Only a mental health professional can make the diagnosis, but you can use some of the standard screening tools to make the appropriate referral. Be sure to get some training and practice on how to use them. These two are available on-line.

Yesavage and Brink's Geriatric Depression Scale

Note that there is a long form and a short form, and the scale is available in many languages through their web page. <http://www.stanford.edu/~yesavage/GDS.html>

Center for Epidemiologic Studies-Depression Scale (CES-D) http://chipts.ucla.edu/Assessment_Instruments/asmt_dp2.html

geon General's report (2000) notes some of the considerations: the TCAs often cause anticholinergic effects—dry mouth, urinary retention, and constipation—which may cause severe problems in older people. These drugs also may interfere with treatment of cardiac disease or produce orthostatic hypotension (dizziness on standing up), which can lead to falls.

SSRIs reportedly have fewer anticholinergic reactions and cardiovascular side effects and are easier to take (one pill once a day), but they can cause insomnia and anxiety, and they may interfere with other medications commonly used by older people (warfarin, calcium channel blockers). Bupropion, a non-SSRI that seems to have fewer side effects and also is used for reducing anxiety, is now often prescribed for older people.

An important thing to remember with these drugs is that their action is not immediate. Their effectiveness seems to result from developing a constant concentration of the drug in the bloodstream. In younger adults, it takes from 4 to 6 weeks (sometimes 6 to 8 weeks) to see a remission in symptoms. The Surgeon General's report (2000) suggests that for older adults, the wait may be longer—8 to 12 weeks.

Another consideration in using these medications is having sufficient funds to continue with the course of treatment. Some older people misuse medications by taking them sporadically—either when they can afford them or when they feel bad—and either strategy makes these psychotropic drugs ineffective at best and harmful at worst.

Psychotherapy

In his presentation at the Geriatric Mental Health Conference in Greensboro in September 2001, Dr. Frederic Blow asked, “Why use psychotherapy for depression if the drugs are so good?” In response, he suggested that psychotherapy has been demonstrated to be an effective treatment for Depression and that there need to be alternative treatments for people who can't or won't take medications or who do not respond to them. Although he suggested that psychotherapy can be provided by professionals who are not physicians (and so provide a less costly service), this treatment may or may not be less costly in the long run. On the other hand, Medicare and Medicaid reimbursement rules may make psychotherapy more affordable to the client, even at more than \$100 per hour of care, than the \$60 to \$80 per month for the medications.

The Surgeon General's Report (2000) briefly describes four types of psychosocial treatments (cognitive-behavioral, problem-solving, interpersonal psychotherapy, brief psychodynamic therapy), remarking that all are effective treatments for Depression.

Electroconvulsive Therapy

People old enough to have seen the movie *The Snake Pit* (1948) and those who remember *One Flew over the Cuckoo's Nest* (1975) may have extreme negative reactions to the idea of electroconvulsive therapy (ECT), but in the past

half-century, there have been many changes in how it is administered. Although it is usually reserved to treat people who do not respond to medications, the Surgeon General's Report (2000) mentions possible advantages for treating older people: reduced side effects and negative interactions with other medications and much quicker relief of symptoms.

Other Options

Mental health diagnosis and treatment of Depression, whether with drugs, psychotherapy, or ECT, are very effective. After considering these alternatives in his presentation at the Geriatric Mental Health conference, Frederic Blow suggested several other things that should be addressed, and many of these are things that clients can do for themselves, perhaps with your assistance:

- ♦ receive correct treatment for other medical disorders
- ♦ manage stress
- ♦ increase their social supports
- ♦ increase their activity level
- ♦ become educated about Depression
- ♦ connect or reconnect with their religion or spirituality.

What Are the Consequences of Not Treating Depression?

Plain and simple: Depression causes deaths. Older adults have the highest rate of suicide deaths of any age group in the U.S. Although older adults were only 13 percent of the population in 1997, 19 percent of suicide deaths in that year were people age 65 and older. Older white men, specifically, are at the greatest risk, with a rate that is about six times the national average for all ages (NIMH 2001). Older adults are also often more successful at taking their own lives than younger people who attempt suicide. See the box on page 4 for some prevention strategies.

Beyond this most dramatic consequence, Depression seems also to be related *independently* to mortality—that is, weed out all the other things that might influence mortality (sociodemographic factors, diagnosed diseases, symptoms, and biological and behavioral risk factors), Depression in and of itself predicts premature death among people who are 65 and older (Schulz et al. 2001). According to Pollock and Reynolds (2000), it also raises the risk for diabetes, osteoporosis, and heart attacks, and “in nursing home patients, [it] increases the death rate by over 50 percent, independent of physical health.”

Because Depression often produces cognitive problems, it is sometimes mistaken for Alzheimer's and other dementias, and it often accompanies dementia. Depression reduces clients' functional abilities, increasing the burden on caregivers or the likelihood of institutionalization. In a small study, Dyer and colleagues (2000) noted a high prevalence of Depression in patients referred for self-neglect, and this may increase the need for adult protective services.

Suicide Prevention

There are several important things to know beforehand:

- ♦ What is your agency's plan for working with clients at risk of suicide? What is your plan?
- ♦ What resources are available in your community, to you as a practitioner and to clients (hot lines, mental health centers, clergy, police, emergency rooms)?

When you work with clients:

- ♦ Be alert for signs that the client is considering suicide ("when I'm gone" or "I just want to die" statements, giving away treasured possessions, putting affairs in order, sudden improvement in mood).
- ♦ Pay attention to somatic complaints. Today's older adults often find it more acceptable to acknowledge physical discomfort than mental discomfort.
- ♦ **Ask** about suicide. ("Have you been thinking about killing yourself?") It won't put the idea into the client's head.
- ♦ If the answer is yes, find out whether the client has a plan and an available method (guns in the house? pills?). Does the client have the skill and knowledge to carry it out?
- ♦ Help the client get help, or do what is needed to preserve the client's safety. Get supervision for yourself.
- ♦ Identify the client's strengths, build in support, and always follow up. Be an advocate for treatment.

While their conclusion was that "geriatric clinicians should rule out elder neglect or abuse in their depressed or demented population," it might make sense to consider the issue the other way around—if you are evaluating abuse, neglect, or self-neglect, it may be very important to have both the client and caregiver evaluated for Depression.

Helping Clients Get Treatment

A brief article by Lachs and Boyer (2000) addresses the hardest part of helping older people get treatment for depression. "It's true that we've developed some remarkably effective medications and nondrug therapies for depression. But translating those discoveries into 'real world' help for an older person suffering from depression just isn't that simple." They point out that some of the problem is the disease itself, which has hopelessness as one of the symptoms. Beyond that, today's older people grew up in a culture where psychiatric disorders carried considerable stigma and where one was expected to deal with personal problems alone.

Lachs and Boyer suggest emphasizing that Depression is a medical illness not unlike other chronic diseases such as diabetes and asthma, for which it would be usual to get a physician's care. They also note that Depression often produces physical symptoms (particularly in older adults), which

is why being examined by a doctor is important—both to rule out other diseases and to help clients seek treatment in a way that may be more acceptable than going to a mental health professional. (With the client's permission, you may want to speak to the physician beforehand and say that you are concerned about Depression. Physicians do not always remember to consider it as a diagnosis.) They also suggest helping the client find ways to increase social contacts—to break "the cycle of isolation and depression." Encourage clients to review activities that used to bring them pleasure, and motivate them to do those activities again. Your functional assessment probably identified these activities, and you may want to help clients build them into the service plan as a means to achieve the goal of reducing depressive symptoms. To make this a measurable goal, you might want to use the Geriatric Depression Scale as a guide to Depression generally and to specific symptoms troubling your client that you may be able to work on together.

Once clients begin a mental health treatment, you can motivate clients to stick with it. You may have to help them find ways to afford the treatment, or your role may be to provide moral support for managing the medications or therapy.

Don't Forget the Caregivers

Family caregivers, many of whom may be "older" themselves, may also suffer from Depression. This may be because they, too, have some of the conditions that often go with Depression. However, they may also have problems specifically related to caregiving. Kosloski and colleagues (1999) provide a good review of the literature on depression and caregiving, although they consider the etiology of Depression more from a social than a medical perspective. In investigating "protective factors"—the things that seem to keep caregivers from developing Depression—they found that satisfaction with emotional support, physical health of the caregiver, and fewer problem behaviors in the care recipient were among the most important.

Social workers can help and encourage caregivers to get the emotional support they need, perhaps through a caregiver support group run by a local Alzheimer's chapter or an adult day care center. In addition, through Area Agencies on Aging, you might have them contact the Family Caregiver Support Specialist about other local opportunities. (See information about this resource at <http://www.dhhs.state.nc.us/aging/fcaregr/fcjobs.htm>). Helping the caregiver get health care services is another important role that may require the social worker to arrange substitute caregiving.



Thanks to Frederic Blow, Geoff Santoliquido, and Suzanne Merrill for their review and suggestions.

More Light and Exercise

One of the diagnostic subtypes of Major Depression in the *DSM-IV-TR* is Seasonal Affective Disorder (SAD), a type of depression that usually manifests itself in autumn and winter, as the amount of daylight diminishes. Treatment for this disorder is exposure to full-spectrum light, using a special light box or visor, usually for 30 minutes in the morning or a bedside light unit set to come on gradually, much like a sunrise. One study, however, suggested that exposure to an hour a day of light in the early morning, even on cloudy days, was about as effective as the more expensive treatments (NMHA 2001). Another suggested that morning light treatments reduced depression in nursing home residents (Sumaya et al. 2001), and another still suggested that treatments may moderate sundowning (Lamberg 1998).

A brief in the *Harvard Mental Health Letter* (March 2001) mentions a study at Duke University that found that for some patients an exercise program of walking, jogging, or cycling relieved moderate depression better than an SSRI (sertraline,

Zoloft®, in this case), or the drug and exercise combined, although all of these treatments produced good results. Singh and colleagues (2001) found that exercise in the form of lifting weights reduced Depression and Dysthymia both in the short- and the long-run (20 weeks and 26 months), and that about a third of the people in their sample continued to exercise on their own.

Given all the difficulties you may face in helping older clients accept, comply with, and afford treatment, when you suspect Depression, you might also help clients (and caregivers) get more exercise and daylight. At its simplest, this might involve having the client open the blinds in the morning or move to a bedroom with an east-facing window. In the community, most senior centers and adult day care centers in North Carolina have exercise programs (often low-impact), and many have such equipment as treadmills, exercise bicycles, and weights. Parks and recreation departments also may offer similar opportunities.

Learn More About Depression

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About Mrs. L.: Suggestions

According to Yesavage, a score of 10 or higher on the Geriatric Depression Scale usually indicates Major Depression. First, determine if Mrs. L. is considering suicide. If she seems not to be in immediate danger, encourage and help Mrs. L. to see her physician to check for contributing physical causes and side effects from her medications (also, she may agree to see him more readily than a mental health provider). He may refer her to a psychiatrist for treatment or to the local mental health center. If she agrees to be treated with medication, you can encourage her to take it as prescribed, because it may take 3 months to see reduced symptoms. You also could work with her and her daughter to increase her social contacts, perhaps by going to a senior center or an exercise program or by getting phone reassurance or a friendly visitor. And you might plan with her that she will go for a short walk in her neighborhood first thing every morning to increase the amount of daylight and exercise she gets.



Ongoing Professional Training from CARES

Sponsored by the Adult Services Branch, NC Division of Social Services

Geriatric Mental Health

Through presentation, case example, and skills practice, this four-day curriculum reviews normal aging, symptoms and treatments of severe and persistent mental illness in older people, methods for working with older clients and their families, legal issues, and resources available. The fee for this event is set by the sponsoring AHEC.

Effective Counseling in Adult Services

This two-day curriculum provides the opportunity to develop skills in counseling adult clients and their families. Participants have the opportunity to practice counseling techniques and learn new skills. The fee for this event is \$35.

Effective Social Work Practice in Adult Services: A Core Curriculum

This six-day training for adult services social workers reviews the family assessment and change process for adult clients and their families. It emphasizes the role of family-centered practice, awareness of and sensitivity to issues of cultural diversity, and skilled counseling and interviewing abilities in excellent practice. The fee for this event is \$50.

Working with Clients with Serious Mental Illness: The DSS Perspective

This two-day curriculum, primarily for DSS social workers, reviews symptoms and treatment of the most common chronic mental illnesses that affect adult services clients and examines the DSS role in working with clients and their families. Mental health consumers and family members themselves offer insight into the challenges of living with severe and persistent mental illness. The fee for this event is \$40.

An Introduction to Aging: Knowledge and Skills for Working with Older Adults and Their Families

This two-day foundation course for health and human services professionals from diverse settings provides basic information and skills needed to work effectively with older people and their families. The training is divided into four modules: Aging Processes, Group and Individual Differences, Changes and Losses, and Practice Challenges. The fee for this event is \$40.

The Adult Services Supervisors' Curriculum

This six-module curriculum is designed to enhance knowledge and skills essential for the administrative, supportive,

and educational functions of an effective adult services manager. Each two-day module provides participants with the opportunity to examine current professional concepts, practice their application, and share ideas and experiences among peers. The fee for this event is \$25 per module. These four modules will be offered in 2001–2002.

Module 1, Supporting Excellent Practice

Module 4, Managing Daily Activities

Module 5, Teaching and Motivating

Module 6, Program Evaluation

Applications in Family-Centered Practice with Adults: The Next Steps

This full-day workshop builds on information taught in Principles of Family-Centered Practice in Adult Services, but it is open to all who work with adults, whether or not they have completed the earlier curriculum. Through case scenarios, discussion, and group exercises, participants will explore real-life applications of the Family-Centered Principles and the corresponding Administrative Principles. The fee for this event is \$20.

About Registration

Contact Libby Phillips at (919) 962-0650 for information about registering for these events. Send a completed registration form with your check made out to UNC School of Social Work to her at

CARES, Jordan Institute for Families
School of Social Work, CB# 3550
University of North Carolina,
Chapel Hill, NC 27599-3550

If your agency is paying your registration fee, you may fax the registration form accompanied by a copy of your agency's authorization of payment to Ms. Phillips at (919) 962-3653. We will make full refunds for cancellation before the deadlines for registration listed on the form. No refund can be made for cancellations after the deadline, but you may send a substitute. If you register using an agency authorization, do not attend, and do not cancel or send a substitute, you or your agency will be billed for the fee. Please call Ms. Phillips at (919) 962-0650 to register a substitute.

If you need the aids or services provided under the **Americans with Disabilities Act** to enable you to attend these events, please contact Ms. Phillips at least one month before the event.

Ongoing Professional Training from CARES, Spring 2002

Please send one registration form per participant. Each participant may register for more than one event using this form. Be sure to mark the dates for which you wish to register. The last day to cancel registration for any event and receive a refund of the fee is the registration deadline date for that event (shown in parentheses). If your agency is paying the registration fee, you may fax this form with a copy of the agency authorization of payment to CARES at (919) 962-3653. Otherwise, please mail this form to us with your check made out to **UNC School of Social Work** or a copy of your agency authorization. Cash payments cannot be accepted. The address is: Center for Aging Research and Educational Services, Jordan Institute for Families, School of Social Work, CB#3550, University of North Carolina, Chapel Hill, NC 27599-3550.

Please Print or Type

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First MI Last

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Work Address _____

City _____ State _____ Zip _____

*Home Phone () _____ **SSN _____

Work Phone () _____ Fax () _____ E-mail _____

**we ask for your home phone in case the training session must be postponed on account of inclement weather*

***used for internal record-keeping and required for those programs that issue CEUs*

Education:

Highest Degree

- HS
- Associate
- Bachelor
- Masters
- Doctorate

Highest Social Work Degree

- BSW
- MSW
- PhD/DSW

Work Type:

- Direct Client Service
- Line Supervisor
- Staff Development
- Program Manager
- Program/Admin. Support
- Director

Employment Type:

- Federal
- State
- County DSS
- County Non-DSS
- Public Univ/College Faculty
- Private Univ/College Faculty
- Private Agency
- Volunteer

Applications in Family Centered Practice with Adults: Next Steps (\$20)

- April 9, 2002, Winston-Salem (March 26)
- April 30, 2002, Wilmington (April 16)
- May 14, 2002, Raleigh (April 30)
- May 17, 2002, Lenoir (May 3)

Effective Counseling in Adult Services (\$35)

- Feb. 25–26, 2002, Greensboro (February 11)
- Mar. 7–8, 2002, Waynesville (February 21)
- May 2–3, 2002, Chapel Hill (April 18)

Effective Social Work Practice in Adult Services: A Core Curriculum (\$50)

- February 19–21 and March 12–14, 2002, Wilmington (February 5)
- April 2–4 and 16–18, 2002, Asheville (March 19)

Effective Supervision and Management in Adult Services (\$25 per module)

- Module 1, April 29–30, 2002, Hickory (April 15)
- Module 4, May 9–10, 2002, Raleigh (April 25)
- Module 5, January 30–31, 2002, Wilson (January 16)
- Module 6, May 29–30, 2002, Winston-Salem (May 15)

Geriatric Mental Health

February 26–27 and March 5–6, 2002, Fayetteville (February 22) \$50. Through SR AHEC; call Joyce Loughlin, (910) 678-7207, for a registration form.

An Introduction to Aging (\$40)

- February 5–6, 2002, Wilmington (January 22)
- April 22–23, 2002, Asheville (April 8)

Working with Clients Who Have Serious Mental Illness: The DSS Perspective (\$35)

- March 18–19, 2002, Raleigh (March 4)

____ Number of Events for Which You Are Registering

Total amount of fees \$ _____

Payment Options:

- Check Enclosed
- Agency Authorization of Payment (check pending)

Please note: Registration forms must be accompanied by a check or an authorization to be accepted.

Could It Be Depression?

Is the client

- ♦ sleeping more or less than usual
- ♦ eating more or less than usual
- ♦ having persistent headaches, stomach aches, or chronic pain?

Ask whether the client feels

- ♦ nervous or “empty”
- ♦ guilty or worthless
- ♦ very tired or slowed down
- ♦ that she/he doesn’t enjoy things as before
- ♦ restless or irritable
- ♦ that no one loves her/him
- ♦ that life is not worth living

If the answer is yes, this person may be suffering from Depression. It’s not a normal part of aging, and she/he should see a doctor or other mental health provider. (Adapted from the NIMH brochure for older people on Depression.)

Flex your mental muscles at CARES’s Spring Training.

Details inside.

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 links to background materials for events, and much more.

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Next time:
**Planning Services with
 Older Clients and
 Their Families**

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