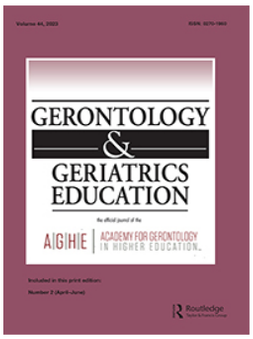

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Enhancing behavioral health competencies for senior center staff through workforce development and training

Bronwyn Keefe[a,b], Corinne A. Beaugard[a], and Jennifer Tripken[c]

[a]School of Social Work, Boston University, Boston, Massachusetts, USA; [b]Center for Aging & Disability Education & Research (CADER), Boston University, Boston, Massachusetts, USA; [c]National Council on Aging, Center for Healthy Aging, Arlington, Virginia, USA

ABSTRACT

Increases in the numbers of older adults with mental health and substance use concerns compel us to identify best practices in training to address these issues. Senior Centers are an ideal location for behavioral health education programs as they are the go-to place for many older adults. This paper describes an online certificate program in Behavioral Health and Aging offered by the Center for Aging and Disability Education and Research at Boston University School of Social Work in collaboration with the National Council on Aging to increase senior center staff knowledge and skills. A total of 228 senior center staff in Illinois, Florida, and Wisconsin completed the online certificate program. There were statistically significant changes in key competencies for all courses based on pre-post assessment. We held key informant interviews to assess the impact of training and participants stated that their knowledge, skills, and behaviors were influenced by the program.

KEYWORDS

Behavioral health; senior centers; workforce development; competency-based training; older adults

Introduction

Providers across the continuum of services for older adults must be attuned to their mental health and wellness needs. In 2019, the U.S. population aged 65 and older numbered 54.1 million, or 16% of the total population (Administration for Community Living, 2021). Projections estimate that the population of older adults will reach 80.4 million by 2040 as adults continue to celebrate their 65th birthdays (Administration for Community Living, 2021). Adequate attention to behavioral health is essential to maintaining older adults' health and wellness, yet these conditions can be challenging to detect, in part due to underreporting (Le Roux Tang, Drexler, & Tang, 2016). A substantial body of evidence has demonstrated that the majority of older adults with mental health and substance use disorders do not get the necessary services and treatment (Mongelli, Georgakopoulos, & Pato, 2020; Byers, Arean, & Yaffe, 2012).

Across the U.S., there are almost 10,000 senior centers. Known in many towns and municipalities as the "go-to" place for assistance, senior centers are often the community front door for social and support services to older adults, families, and caregivers. Senior centers are vital hubs for older adults and are community-based settings where older adults

CONTACT Bronwyn Keefe bronwyn@bu.edu Center for Aging & Disability Education & Research (CADER) & Network for Professional Education, Aging Specialization and Lowy-GEM Program and School of Social Work, Boston University, 264 Bay State Road, Boston, Massachusetts 02215, USA

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receive support for social, health, and wellness goals (Orellana et al., 2020; Pardasani & Sackman, 2014). In addition to the benefits of socialization, senior centers provide comfortable, non-clinical settings where older adults seek guidance on mental and physical health concerns (Pardasani & Berkman, 2021). Senior center staff can assist older adults by sharing community resources for individuals who may be experiencing a mental health or substance use issue. However, older adults with mental health or substance use disorders may go unnoticed by staff at senior centers who are not adequately trained to detect these conditions and make the appropriate referrals (IOM (Institute of Medicine) et al., 2012). Training programs for senior center staff offer one effective approach to increasing staff skills by enhancing their capacity to support the behavioral health needs of older adults (Liao & DeLiema, 2021).

To address this gap, The Center for Aging & Disability Education & Research (CADER) at Boston University School of Social Work developed a Behavioral Health and Aging (BHA) five-course online, self-paced certificate program for the workforce supporting older adults. The BHA program is a 19-hour online certificate program that includes the following five courses: 1) Mental Health and Aging Issues; 2) Substance Use among Older Adults; 3) Mental Wellness and Resilience Among Older Immigrants and Refugees; 4) Suicide Prevention among Older Adults; and 5) Alzheimer's Disease and Other Dementias. The primary learning goals of the BHA program are to enhance knowledge related to each topic area, increase early detection of behavioral health concerns, provide better programming around mental wellness for older adults attending senior centers, and increase referrals to mental health providers for people who need additional services.

It is well-known that competency-based trainings are a pragmatic and effective way to enhance the skill sets of staff at community-based agencies to identify, support, and refer older adults to necessary care (Mezey, Cortes, Burger, Clark, & McCallion, 2010). Prior to creating the BHA program, CADER reviewed preexisting behavioral health competencies including those developed by the Gero-Ed Center of the Council of Social Work Education, Pikes Peak Model for Training in Professional Geropsychology, Geropsychiatric Nursing Collaborative, the Administration on Aging, Older Americans Behavioral Health Issue Briefs, and SAMHSA. There were limited competencies related to key geriatric behavioral health practices for community-based providers. In response, CADER gathered a team of subject matter experts, social work practitioners, and researchers to devise a set of behavioral health competencies for community practice. These competencies were designed to guide content development and enhance providers' knowledge, skills, and attitudes when working with older adults who have behavioral health concerns.

CADER worked with senior centers in Florida, Illinois, and Wisconsin from 2018–2021 to train a total of 250 staff members using the five-course BHA online certificate program. The primary aim was to assess whether this training improved staff knowledge and skills to support older adults experiencing behavioral health challenges. The secondary aim was to identify facilitators and barriers to BHA completion, perceived importance, impact on types and quality of services delivered to older adults, and sustainability of offering BHA training to new staff.

Methods

The Behavioral Health and Aging (BHA) Certificate online program was created by CADER and delivered in collaboration with the National Council on Aging (NCOA) to train staff at

senior centers in Florida, Illinois, and Wisconsin. The training was delivered using a five-course online, self-paced certificate program. We began the project in 2018 with the objective to train 200 staff members at senior centers in Florida and Illinois (100 per state) on the core skills, knowledge, and attitudes needed to identify and respond to older adults with mental health and substance use concerns. In December 2019, the project was replicated in Wisconsin with a cohort of 50 staff members at senior centers. These states were chosen because of geographical funding priorities for the sponsor and because of strong relationships between state senior center associations and NCOA.

Participants

NCOA worked directly with the state senior centers association in each of the three states to ensure broad outreach and dissemination of the project opportunity. The state associations recruited senior center staff involvement from rural, suburban, and urban senior centers in order to have diverse representation. The outreach materials described the BHA certificate program along with expectations for completion and a timeline. The state senior center associations disseminated these materials to senior center directors and staff across their state. The program was open to all levels of staff at the senior center, including front desk staff, outreach workers, and center directors. Participants self-selected their interest in the program and spots were assigned on a first-come, first-serve basis. We also created a waitlist as there were more people interested in the training than available spots through this funding. Once we had a final participant list, people were invited to register for the program. Each agency had its own set of expectations for when the online certificate was to be completed: some agencies provided time during the work day and other participants completed it on their own time outside of work. The online certificate program was provided by CADER at no cost to the senior centers due to external grant funding. We provided an incentive for participants who completed all of the courses and questionnaires in the form of a $250 gift card; this was raffled off to one person.

Measures and procedures

Prior to beginning the program, participants completed a self-assessment related to their skill level with each competency identified as a key practice area. This was assessed using a five-point Likert scale ranging from the following: No experience = 0, Beginning skill = 1, Moderate skill = 2, Advanced skill = 3, and Expert skill = 4. Thus, participant scores in each of the practice areas could range from 0–4. After completing the courses, participants completed a second self-assessment rating on the same competencies. Course competencies are presented in Appendix A.

Analysis

We calculated descriptive statistics, means and standard deviations, frequencies, and percentages in SAS Studio. The Likert scale responses were treated as continuous data (de Winter & Dodou, 2010). The change between the self-assessments before and after each course was calculated with a paired t-test. Cohen's d was calculated as a measure of effect size; effect sizes above .8 are considered large (Brydges, 2019). A total of 228 participants

completed at least one course, but all participants did not complete all courses. The pretest and posttest statistics were calculated with the sub-sample of participants who completed each course. The sample size for individual course completion ranged from 159–200. All Type II errors were set at .05.

Key informant participants

Key informant interviews were conducted at two points in time after the completion of the BHA program: June 2019-July 2019 ($n = 4$) and September 2020-October 2020 ($n = 11$). All participants who completed the BHA program were sent an e-mail invitation to participate in an interview. Fifteen participants voluntarily took part in an individual semi-structured interview to share their experience of the BHA certificate program. These 15 participants represented senior centers from all three states and were mostly senior center staff. Only one participant identified as the director of a senior center. No compensation or remuneration was provided to participants for their involvement in the interviews.

Key informant interviews

The interview guide solicited information about the facilitators and barriers to completion of the program, the perceived importance of the program content, and the impact of the program on their daily interactions and work. Participants were also asked about their ideas for expanding and sustaining the BHA program at their workplace.

Key informant analysis

All interviews were recorded, and the data was transcribed verbatim. Interviews were analyzed using a content analysis approach, starting with familiarization with the data, followed by emergent coding drawn from the text and a priori template coding (Downe-Wamboldt, 1992; Krippendorff, 1980). From this, the data was coded and key themes were identified. Codes and themes were analyzed by two researchers to account for internal validity. Coding discrepancies were discussed to achieve consensus. Participation in the study was voluntary; and participation, nonparticipation, and withdrawn participation did not affect participants' relationship with the researchers or their involvement in the program.

The Boston University Institutional Review Board (IRB) determined that the study protocol (1235×) was not human subjects research and that it, therefore, did not require IRB review.

Results

Quantitative results

A total of 228 participants (demographic characteristics in Table 1) completed at least one course. Most participants were located in Florida (38%) and Illinois (38%), with the remainder in Wisconsin (24%). In the Florida and Illinois cohort, 200 learners enrolled and 167 learners completed (84%) the BHA program. In the Wisconsin cohort, 50 learners

Table 1. Demographics of People Enrolled ($N = 228$).

		n (%)
Race	African American/Black	34 (15.67%)
	Asian	4 (1.84%)
	Hispanic/Latino	17 (7.83%)
	White	152 (70.05%)
	Other	10 (4.61%)
Gender	Male	20 (9.17%)
	Female	198 (90.83%)
State	Florida	83 (37.90%)
	Illinois	84 (38.36%)
	Wisconsin	52 (23.74%)
Education	No Postsecondary Degree	36 (16.59%)
	Associate Degree	23 (10.6%)
	Bachelor's Degree	82 (37.79%)
	Master or Professional Degree	76 (35.02%)
Work Setting	Adult Day Care	18 (8.29%)
	Adult Protective Services	3 (1.38%)
	Aging Disability Resource Center	13 (5.99%)
	Area Agency on Aging	16 (7.37%)
	Senior Center	146 (67.28%)
	Other	20 (9.67%)

enrolled and all of them completed (100%) the program. These completion rates highlight the ease of access and value of the program for this workforce.

Almost all participants identified as female (91%) and more than two-thirds identified as white (70%). The average age was 47, and ages ranged from 21–75 years old. Nearly 40% completed a bachelor's degree and over one-third completed a master's or professional degree. While the target training audience was senior center staff (almost 70% enrolled), a few participants from other community-based agencies were also invited to enroll in the program.

All competencies were significantly improved after taking the associated course ($p < .001$), with a substantial proportion of participants reporting that they had no experience or beginning experience skill level in key behavioral health competencies in the pretest. After taking the BHA certificate program, the proportion of participants reporting moderate to advanced skills increased. These competencies were all significantly improved with a large effect size (Cohen's d > .80). The two most significant competencies measured pre-post for the Mental Health and Aging course were: "Demonstrate an understanding of the core elements of a mental health assessment including standardized assessment tools," ($M = 1.16$, $SD = 0.90$ vs $M = 2.00$, $SD = 0.78$), $t(199) = 13.16$, $p < .0001$, Cohen's d = .93) and "Explain how utilizing individual and group interventions are appropriate for addressing the mental health of older adults," ($M = 1.08$, $SD = 0.91$ vs. $M = 2.08$, $SD = 0.80$, $t(199) = 15.39$, $p < .0001$, Cohen's d = 1.09). The two most significant competencies measured pre-post for the Substance Use Among Older Adults course were: "Engage in a collaborative process of addressing substance use with the older adults with whom you work," (M= 0.92, SD=0.91 vs. $M = 2.19$, $SD = 0.84$, $t(197) = 17.16$, $p < .0001$, Cohen's d = 1.22) and "Utilize evidence-based models for addressing substance use including SBIRT," ($M = 0.34$, $SD = 0.65$ vs. $M = 1.95$, $SD = 0.78$, $t(197) = 24.77$, $p < .0001$, Cohen's d = 1.76). The two most significant competencies measured pre-post for Suicide Prevention among Older Adults course were: "Describe the skills that are needed to assess and intervene with a suicidal older adult," ($M = 1.02$, $SD = 0.87$ vs. $M = 2.15$, $SD = 0.87$, t

(199) = 17.43, $p < .0001$, Cohen's d = 1.23) and "Describe collaborative emergency plans that can impact the older adult's safety when they are at risk of suicide," $M = 0.96$, $SD = 0.83$ vs. $M = 2.18$, $SD = 0.81$, $t(199) = 18.87$, $p < .0001$, Cohen's d = 1.33). The two most significant competencies measured pre-post for the Alzheimer's Disease and Other Dementias course were: "Describe psychosocial interventions that can be utilized with people with dementia," ($M = 1.18$, $SD = 0.92$ vs. $M = 2.29$, $SD = 0.80$, $t(199) = 13.77$, $p < .0001$, Cohen's d = .97) and "Become familiar with available testing and diagnostic tools that can help determine the presence of dementia," ($M = 1.15$, $SD = 0.96$ vs. $M = 2.36$, $SD = 0.78$, $t(199) = 12.27$, $p < .0001$, Cohen's d = .87). And lastly, the two most significant competencies measured pre-post for Mental Wellness and Resilience Among Older Immigrants and Refugees course were: "Understand the background of immigration in the U.S. and its relationship to the work you do with older immigrants and refugees," ($M = 0.86$, $SD = 0.89$ vs. $M = 2.10$, $SD = 0.76$, $t(158) = 17.76$, $p < .0001$, Cohen's d = 1.36) and "Identify the strengths and resources in immigrants and immigrant communities that build resilience," ($M = 0.86$, $SD = 0.83$ vs. $M = 2.11$, $SD = 0.82$, $t(158) = 16.15$, $p < .0001$, Cohen's d = 1.28). Percentages from participants' pre and post-self-ratings of these competencies are presented in Table 2.

It is noteworthy that most of the participants revealed low skill levels in screening, assessment, and appropriate interventions for older adults who have behavioral health concerns. It is also important to consider the low self-assessments from this group of learners in understanding how the immigration experience might impact older adults and how to build upon and support the strengths of diverse communities. These findings articulate a need for training programs that focus on these key areas in order to improve the health and well-being of all adults.

Qualitative results

A total of 15 interviews were conducted. Of the 15 participants, ten had completed the BHA program within the previous 6 months of the interview. Five participants were at least 6 months out from completion of the BHA program. Table 3 identifies the themes and subthemes that emerged from our research questions

Several questions were asked about the perceived importance of the BHA certificate program to gain a better understanding of the change in thoughts, behaviors, and skills as they relate to behavioral health issues in aging and how these changes manifested in practice. Many participants discussed both the importance of the courses and how they would implement the course material. Four themes emerged from this construct: 1) changes in thoughts, skills, and behaviors; 2) memorable aspects of the program; 3) individual impact; and 4) organizational impact.

Changes in thoughts, skills, and behaviors

Two subthemes emerged from the questions related to the perceived importance and how participants felt that their thoughts, skills, and behaviors were influenced by the program. Many participants mentioned that they felt more aware and knowledgeable about the various mental health issues impacting older adults. One participant shared,

> "I feel more observant. Because now that we have read the material of how to identify certain things when we talk to participants that might be dealing with depression, it's easier to kind of

Table 2. Course Competencies (pre-posttest).

Mental Health and Aging Competencies ($N = 200$)		
Demonstrate an understanding of the core elements of a mental health assessment including standardized assessment tools.	Pre-test	Post-test
No experience	54 (27.00%)	5 (2.50%)
Beginning skill	73 (36.50%)	40 (20.00%)
Moderate skill	62 (31.00%)	110 (55.00%)
Advanced skill	10 (5.00%)	40 (20.00%)
Expert skill	1 (0.50%)	5 (2.50%)
Explain how utilizing individual and group interventions are appropriate for addressing the mental health of older adults.		
No experience	63 (31.50%)	5 (2.50%)
Beginning skill	71 (35.50%)	37 (18.50%)
Moderate skill	55 (27.50%)	101 (50.50%)
Advanced skill	10 (5.00%)	52 (26.00%)
Expert skill	1 (0.50%)	5 (2.50%)
Substance Use Among Older Adults Competencies ($N = 198$)		
Engage in a collaborative process of addressing substance use with the older adults with whom you work.	Pre-test	Post-test
No experience	80 (40.4%)	5 (2.53%)
Beginning skill	63 (31.82%)	33 (16.67%)
Moderate skill	47 (23.74%)	86 (43.43%)
Advanced skill	7 (3.54%)	68 (34.34%)
Expert skill	1 (.51%)	6 (3.03%)
Utilize evidence-based models for addressing substance use including SBIRT.		
No experience	147 (74.24%)	3 (1.52%)
Beginning skill	36 (18.18%)	51 (25.76%)
Moderate skill	13 (6.57%)	100 (50.51%)
Advanced skill	2 (1.01%)	40 (20.20%)
Expert skill	0	4 (2.02%)
Suicide Prevention among Older Adults Competencies ($N = 200$)		
Describe the skills that are needed to assess and intervene with a suicidal older adult.	Pre-test	Post-test
No experience	62 (31%)	3 (1.5%)
Beginning skill	83 (41.5%)	37 (18.5%)
Moderate skill	45 (22.5%)	91 (45.5%)
Advanced skill	9 (4.5%)	66 (33%
Expert skill	1 (.5%)	3 (1.5%)
Describe collaborative emergency plans that can impact the older adult's safety when they are at risk of suicide.		
No experience	67 (33.50%)	2 (1%)
Beginning skill	82 (41%)	39 (19.5%)
Moderate skill	44 (22%)	87 (43.50%)
Advanced skill	7(3.5%)	66 (33%)
Expert skill	0	6 (3%)

(*Continued*)

Table 2. (Continued).

Alzheimer's Disease and Other Dementias Competencies ($N = 200$)		
Describe psychosocial interventions that can be utilized with people with dementia.	Pre-test	Post-test
No experience	57 (28.50%)	1 (.50%)
Beginning skill	77 (38.50%)	26 (13.0%)
Moderate skill	46(23.0%)	82 (41.0%)
Advanced skill	19 (9.50%)	82 (41.0%)
Expert skill	1 (.50%)	9 (4.50%)
Become familiar with available testing and diagnostic tools that can help determine the presence of dementia.		
No experience	51 (25.50%)	34 (17.0%)
Beginning skill	80 (40.0%)	84 (42.0%)
Moderate skill	53 (26.50%)	73 (36.50%)
Advanced skill	15 (7.50%)	9 (4.50%)
Expert skill	1 (.50%)	0
Mental Wellness and Resilience Among Older Immigrants and Refugees Competencies ($N = 159$)		
Understand the background of immigration in the U.S. and its relationship to the work you do with older immigrants and refugees.	Pre-test	Post-test
No experience	67 (42.14%)	1 (.63%)
Beginning skill	54 (33.96%)	31 (19.50%)
Moderate skill	32 (20.13%)	82 (51.57%)
Advanced skill	5 (3.14%)	41 (25.79%)
Expert skill	1 (.63%)	4 (2.52%)
Identify the strengths and resources in immigrants and immigrant communities that build resilience.		
No experience	63 (39.62%)	4 (2.52%)
Beginning skill	59 (37.11%)	31 (19.50%)
Moderate skill	33 (20.75%)	70 (44.03%)
Advanced skill	4 (2.52%)	52 (32.70%)
Expert skill	0	2 (1.26%)

Table 3. Themes and Subthemes.

Themes	Subthemes
• Changes in thoughts, skills, and behaviors	• Perceived importance • Training programs influence on thoughts, skills, and behaviors
• Memorable aspects of the program	• Course content • Discussion boards and case studies
• Individual impact	• Enhanced ability to recognize behaviors associated with behavioral health issues • Increased confidence, due to enhanced skills and awareness of resources
• Organizational impact	• Increased educational groups and sessions around behavioral health issues • Enhanced community partnerships

recognize some of the signs." Another participant added, "When going through [the program], I was thinking of some people and wishing I could see them again, to watch their behaviors now that I had this other information." The other subtheme related to having more resources for addressing behavioral health issues. One participant said, "I feel more prepared to provide guidance for my staff when working with the populations that I now know more about." Another participant shared that she has a client who was struggling with depression and grief, "I took the course and was able to identify some resources and connect her with places that might be able to help her with her depression as she goes through the situation."

Memorable aspects

Participants were asked about the most memorable aspect of the BHA certificate program. In general, participants agreed the case studies and the discussion boards were enjoyable and enhanced the learning. The course on Mental Wellness and Resilience Among Older Immigrants and Refugees was noted as the most memorable of the five courses. One participant said:

> In the Mental Wellness and Resilience Among Older Immigrants and Refugees course, the defining of needs of diverse populations was most powerful since I am a suburban kid who doesn't know that. Even though you think you know what they need, you don't know. Cultural sensitivity or humility - even though we talk about it, because the module was so in-depth, it was more powerful.

Another participant echoed this lack of familiarity and appreciation for the increased insight:

> To see the world through their eyes – to understand that they left everything, and they are fearful – to see that we are getting them into programs, rethinking how we offer programming and how we interact with them. Some would say they are so closed off. We now know it is for a reason.

Individual impact

Participants were asked to comment on how they think the BHA program would have an impact on the older adults with whom they worked. Two subthemes were identified from this theme. The first was that participants shared that they were more confident in their ability to recognize behaviors associated with mental health and substance use issues. One participant said:

> I think it'll help with my observance of some older adults that might be facing issues that I might not have been aware of in the past or might have overlooked in the past and then be able to make an appropriate referral.

The second subtheme was an increase in confidence, due to enhanced skills and awareness of resources. A participant shared,

> "For me, I have an increased confidence in addressing or evaluating what I'm seeing." Another participant said, "I would say that for me that it bolstered my confidence and I'm more aware of resources out there and where to go."

Organizational impact

All participants were optimistic about integrating the BHA courses into additional programs and policies at their organization. Two subthemes were identified about suggested programs related to the BHA program. The first subtheme was offering more educational groups and sessions around behavioral health issues. Several participants mentioned they felt there was an opportunity to integrate more educational and screening sessions into their senior center offerings. A participant said:

> They may not know what they are experiencing. You know, "maybe I didn't realize that I haven't been going out anywhere" and you know, "maybe I drink too much." You know they don't realize it until it gets pointed out to them. So maybe just an educational or informational session.

The second subtheme identified was around enhanced partnerships. Participants mentioned partnering with community resources to serve as speakers and as resources for referrals. A participant said:

> I would like to see how I could partner if there's a professional, you know psychiatrist, in the area or someone that could come in and do a presentation. Where they can say I'm coming to get this information for a friend or I'm coming to get it . . . finding someone to make a link within the community.

Another participant also shared:

> I live in a small rural community, and we do have connections to our mental health providers, but we have very few mental health providers. So, I think I would encourage employees to really start reaching out to them to see what we could start offering jointly.

Notably, all participants mentioned that stigma around behavioral health issues would be a barrier to older adults' participation in events. A participant shared,

> "My thoughts are that they may be hesitant to come in because they don't want to know the answer. They'll stay away. So, I think that even though they might have a problem, it is that fear." Another participant mentioned that they felt that older adults would be hesitant to join a program that addresses behavioral health. They said, "They see this as a weakness. That might be a hard struggle." This was expressed as a deeper issue with programs and services being offered remotely. A participant said, "Sometimes at a senior center, the person will say I'm just going to go in here since I'm here . . . even though that's not the reason they came. The stigma."

Some participants reported changes to their organizational offerings through programs, policies, and partnerships since taking the BHA program. Two participants mentioned that

their organization had implemented new programs to address behavioral and mental health needs. One participant said:

> There was a program and it's related to alcohol use. It's more so a support group . . . So now they're doing things virtual online, but there's still quite a bit of a turnout. Its focus is on alcohol abuse prevention and then there's also another caregiver support group that started.

Another participant shared that their organization is doing programming around memory care cafes (a program for people with Alzheimer's disease or related dementias) for older adults and their caregivers. One participant reported that their organization made a policy change by including a new form in their screening process. The participant explained:

> We lacked a referral form for counseling. We added a new form that asked about how they have been feeling, what that feels like, and how long they've been feeling this way. And the form included the family and if they had family support.

Several participants stated that they formed new partnerships with other community organizations. One participant shared that their organization 'has really been enhancing our mental health services and our work with licensed mental health counselors and social workers and reported that the BHA program "fortified our foundation or understanding of what is happening with mental health."

Discussion

As the population ages, the number of older adults with mental health and substance use concerns increases. Senior centers are a primary location where older adults connect with the community and resources. Though recreational and social needs may draw older adults to senior centers, well-trained senior center staff can also support older adults with critical referrals for mental health and substance use issues.

Many older adults manage their emotional well-being in the face of increasing aging-related challenges; however, according to the World Health Organization (2017), 15% of older adults have some type of psychological disorder. Depression is the most prevalent psychological concern among older adults (approximately 8–16%) and subclinical depression affects an even greater number (10–50%) (Haigh, Bogucki, Sigmon, & Blazer, 2017). The rate of suicide completion increases across the lifespan, with older adults accounting for 18% of suicides each year, although only 12% of the population (Conejero, Courtet, & Calati, 2018). Senior center staff are well-poised to support older adults during periods of crisis, however, without the confidence to identify signs and symptoms, their effort to provide a successful intervention can be hampered. The range of psychological and social concerns experienced by older adults demonstrates the value that enhanced training for staff would have for the older adults who frequent senior centers. One study surveyed 597 older adults who attended senior centers and found that 32.2% screened positive for depression, 21.6% screened positive for anxiety, and 12% for alcohol use disorder (Pardasani & Berkman, 2021). These data support the general understanding that psychological distress and substance use concerns are prevalent among older adults who were not in a treatment-seeking environment. Preparing senior center staff to support this subgroup of older adults could have lifesaving results.

There is also an increasing prevalence of substance use disorders (SUD) among older adults (Substance Abuse and Mental Health Services Administration SAMHSA, 2019). Interacting with older adults around this highly stigmatized experience is challenging to navigate, yet it is critical that senior center staff learn how to engage with the older adults who present warning signs. The potential harms associated with SUDs, such as decreased quality of life, increased physical health problems, and death warrants adequate training and attention (Le Roux Tang, Drexler, & Tang, 2016).

Value of workforce training

Training staff in community-based agencies can be a powerful intervention to increase knowledge and skills in behavioral health, which can result in better outcomes for older adults. In addition, increased training can lead to more programs addressing behavioral health, which can open up discussions around these topics and reduce stigma. As demonstrated by these findings, participants felt more confident in key mental health and substance use practice areas. Since professional self-efficacy has been associated with enhanced self-development and performance outcomes, taking the BHA program is one path toward improved service delivery for older adults (Mbao, Keefe, Almeida, & Hamilton-Mason, 2023; Bandura, 2012; Jiang et al., 2018).

Throughout the BHA program, learners commented on the ease of use of the online courses and their convenience. Being able to learn anywhere, anytime is a great facilitator of learning. It also enables replication anywhere across the country and internationally. In addition, participants noted the blogs, case studies, and discussion boards, as some of the most memorable aspects of the courses. These provided an interactive element that is an important part of best practices in adult learning and in achieving a high degree of course completion. These elements make it a convenient, accessible experience for all levels of learners in the aging network across a diverse range of community-based agencies.

Diversity

As older adults become a more diverse group, it is essential to consider how diversity influences older adults' mental well-being, health inequity, and access to care. Participants who completed the course on Mental Wellness and Resilience Among Older Immigrants and Refugees indicated their general unfamiliarity with this population, thus reinforcing the importance of offering courses with this focus. Older adults are becoming increasingly diverse. In 2019, approximately one in six people over the age of 65 were foreign-born, a 108% increase since 2000 (Camarota & Zeigler, 2019). Their path to treatment is complicated by the healthcare system, legal, and language barriers. Cultural norms also contribute to different presentations of psychological disorders and SUDs; without training, these cues may be easy to miss. Given increased cultural diversity, professionals working with older adults must be skilled enough to understand and support the needs of this population.

Next steps

National organizations such as the Institute of Medicine, SAMHSA, NCOA, and the National Coalition on Mental Health and Aging have been calling attention to the need for training in the area of behavioral health and aging and for "critical strategies to address the current and future shortfall" (National Council on Aging NCOA, 2018). Training staff at senior centers is one strategy to address this need. The high completion rates, significant changes in competencies, and desire for more training, all speak to the success of this program. People who completed the BHA program were satisfied with the course materials and described numerous opportunities for professional growth at the individual and organizational levels. Future efforts should focus on understanding the perspective of senior center directors and leadership to further extrapolate the impact of the BHA program on organizational programs and policy change. Additional state and federal funding is needed to support workforce training in order to sustain these important training initiatives and improve the care of older adults.

Limitations

Perhaps the greatest limitation of this study is that these results were based on self-assessment of perceived competencies in key areas, which could be considered less credible than objectively measured changes in competencies. Future research should consider more objective ways to measure change, such as gathering information from participants' managers or looking at outcome data for older adults who visit senior centers. An additional limitation is around the generalization of the findings from the course on Mental Wellness and Resilience Among Older Immigrants and Refugees as the older adult immigrant and refugee populations vary from place to place; therefore, it would be valuable to design future trainings with focused materials on specific immigrant populations for different geographic locations.

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Appendix A: Competencies for all Courses

Mental Health and Aging

(1) Describe the signs and symptoms of the common mental health conditions that can affect adults as they age.
(2) Identify the issues related to losses, changes, and transitions over the life cycle relevant to the mental health of older adults.
(3) Describe the risk and protective factors for suicide in older adults.
(4) Demonstrate an understanding of the core elements of a mental health assessment including standardized assessment tools.
(5) Explain how utilizing individual and group interventions are appropriate for addressing the mental health of older adults (e.g., cognitive behavioral therapy, problem-solving therapy, psycho-educational groups, and supportive therapy).
(6) Identify some of the resources and resource systems available for older adults and their families.
(7) Explain the older adult's right to dignity and self-determination when addressing psychosocial and mental health issues of older adults.
(8) Develop the ability to relate one's own values and biases to aging and mental health issues.
(9) Develop an understanding of the impact of culture when addressing mental health issues facing older adults.

Substance Use Among Older Adults

(1) Gain knowledge of the impact of substance use on an older adult's health.
(2) Identify standardized screening and assessment tools that are appropriate for use with older adults, such as the MAST-G and AUDIT.
(3) Develop an awareness of treatment and recovery models and resources, and know how to make referrals.
(4) Engage in a collaborative process of addressing substance use with the older adults with whom you work.
(5) Understand and address the barriers that might impact substance use interventions.
(6) Utilize evidence-based models for addressing substance use including SBIRT.
(7) Understand individual and societal attitudes toward substance use in older adults.
(8) Identify and assess one's own values and biases regarding aging and substance use.
(9) Respect the older adult's right to dignity and self-determination in relation to substance use.

Suicide Prevention Among Older Adults

(1) Describe the potential impact of ageism as it relates to older adults and suicide.
(2) Describe the limits of confidentiality as it relates to potential self-harm.
(3) Discuss the ethical dilemmas that may exist between the worker's goals to prevent suicide and the consumer's goals to eliminate psychological pain.
(4) Describe the basic concepts of suicide and suicide prevention.
(5) Understand the risk factors and protective factors associated with suicide.
(6) Understand and manage one's own reactions to suicide.
(7) Describe the skills that are needed to assess and intervene with a suicidal older adult.
(8) Describe collaborative emergency plans that can impact the older adult's safety when they are at risk of suicide.

Alzheimer's Disease and Other Dementias

(1) Identify the most common types of dementia.
(2) Understand the core clinical criteria used for diagnosing dementia.
(3) Understand the stages of Alzheimer's disease.
(4) Become familiar with available testing and diagnostic tools that can help determine the presence of dementia.
(5) Describe effective person-centered communication strategies to use with people with dementia.
(6) Describe psychosocial interventions that can be utilized with people with dementia.
(7) Develop awareness of resources and interventions that can assist caregivers.
(8) Respect and promote the person's right to dignity and self-determination throughout the stages of these diseases.
(9) Understand common legal and ethical dilemmas that may affect people with dementia and their caregivers.
(10) Respect diversity, cultural values, and beliefs of people and their families.

Mental Wellness and Resilience Among Immigrants and Refugees

(1) Understand the background of immigration in the U.S. and its relationship to the work you do with older immigrants and refugees.
(2) Identify the stressors and barriers faced by older immigrants and refugees.
(3) Identify the strengths and resources in immigrants and immigrant communities that build resilience.
(4) Utilize information about depression in your work with older immigrants and refugees.
(5) Describe methods of recognizing and promoting resilience.
(6) Describe interventions you can utilize to promote mental wellness with older immigrants and refugees.
(7) Discuss your own cultural attitudes and beliefs and how they may affect your work with immigrants and refugees.
(8) Describe how stigma related to immigration status might impact self-esteem.