STUDY BY THE STAFF OF THE U.S.

General Accounting Office

The Elderly Remain In Need Of Mental Health Services

Professionals are concerned that the mental health needs of the elderly are not adequately understood or addressed by community mental health centers, nursing homes, and other providers. Older persons remain disproportionately underserved in the community, and mental health treatment in nursing homes is rare.

This study describes mental health services provided to the elderly just before the implementation of the mental health and substance abuse block grant. It is made available to help the States, grantees, and other public agencies develop and improve mental health services for the elderly.

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PREFACE

In recent years professionals and legislators knowledgeable about aging have become concerned that the mental health needs of older persons are largely ignored. Experts agree that the elderly have a greater need for mental health services than does the population at large, yet elderly clients are seen infrequently by public and private mental health providers.

These concerns are not unfounded. The results of our study of mental health services for the elderly, undertaken just before the consolidation of federally funded mental health services into block grants, indicate that the elderly receive little attention from public mental health agencies.

This staff study describes the status of services for older clients as reflected in the literature and as found during visits to mental health agencies and nursing homes in two States during 1981. Also discussed are barriers to service development and their implications for an aging population. Responsibility for CMHC program administration has now been turned over to the States, with Federal funding coming through the block grants. Each State will now determine its own method of providing mental health services to the elderly.

We discussed the information in this staff study with mental health professionals of the National Institute of Mental Health. It is hoped that this information will be of use to States, grantees, and professionals in their efforts to develop and improve mental health services for the elderly.

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ABBREVIATIONS

AAA	area agency on aging
C&E	consultation and education
CMHC	Community Mental Health Center
HHS	Department of Health and Human Services
ICF	intermediate care facility
NIMH	National Institute of Mental Health
SNF	skilled nursing facility

CHAPTER 1

OLDER PERSONS RECEIVE LITTLE MENTAL HEALTH CARE FROM MENTAL HEALTH AGENCIES AND NURSING HOMES

One out of every nine Americans has reached age 65--euphemistically called the "golden years." Passing from middle age into the golden years in America today can be a rewarding experience as demands ease and time for family, friends, and leisure increases. For many, however, it can also be a time of troubles. Retirement and role changes require adjustments, as can the loss of a spouse or friends. Also, old age sometimes brings declining health. These stresses, which often accompany advancing age and other factors, such as poor nutrition or overmedication can threaten the psychological well-being of older persons, creating a need for a mental health care system adept at identifying the at-risk elderly and helping them and their families.

Experts agree that older persons generally have greater needs for mental health services than does the population at large. Acute problems, such as depression, are common reactions to failing health and other involuntary life changes. Also, chronic mental problems, experienced by deinstitutionalized mental patients and others presently able to live in the community, may become more difficult to manage during old age. In addition, many families struggle to help elderly relatives cope with the yet-unexplained decline in mental function that affects some older persons--a condition commonly called senility.

As a practical matter, the mental health needs of older persons overlap those of the general population. But because of differences in attitudes, activities, lifestyles, and other psychosocial factors, specialized approaches are needed to reach the elderly. Strategies useful for identifying, assesing, and treating children and adults have proven less successful in dealing with the elderly. To serve them effectively, professionals must understand the unique physiological and psychological characteristics of older individuals.

We visited 3 public mental health providers and 10 nursing homes in New York and Texas to examine how they responded to their mandates to serve the older population. We found that the continuing emphasis the Congress has placed on serving the elderly in mental health legislation had not been translated into effective service delivery by Community Mental Health Centers (CMHCs) in those States. Few legislatively mandated specialized services for the elderly were being provided. In addition, although nursing homes have become frequent health care providers for the elderly with mental problems, the treatment provided remains almost exclusively focused on physical illnesses.

COMMUNITY MENTAL HEALTH CENTERS

The CMHC Program, created in 1963, has been the principal Federal response to the mental health needs of noninstitutionalized individuals. This program, and the advent of psychotropic drugs, facilitated the trend of the last 2 decades to treat individuals in the community, as opposed to institutions. This trend--commonly referred to as deinstitutionalization--resulted in the release of thousands of former State psychiatric hospital inpatients and sharp reductions in new mental hospital admissions.

Essentially, CMHCs are local agencies which receive Federal seed money to provide mental health services to all individuals in a defined geographic (catchment) area. Services are to be available to individuals regardless of age, ability to pay, and current or past health conditions. Services provided include screening and assessment; inpatient, outpatient, and emergency care; day care; rehabilitation; and followup services for deinstitutionalized psychiatric patients. While these services are provided to individuals of all ages, federally funded CMHCs have been required to develop and provide specialized services for the elderly, including a full range of diagnostic, treatment, liaison, and followup services.

CMHCs also provide mental health consultation and education (C&E) services to schools, courts, social and health service agencies, and other organizations. C&E increases public awareness of the center, the nature and treatment of mental health problems, and the services available.

In fiscal year 1981, 485 CMHCs were funded through direct Federal grants. Since 1965, 781 centers had been funded; currently, just over half the people in the Nation reside in a catchment area covered by an operational CMHC. Mental health catchment area populations range from about 75,000 to 200,000, and their boundaries do not necessarily match those of local governments or other public programs. CHMCs exist in a variety of forms. Some are operated as part of a general hospital or a State psychiatric hospital, while others are free standing, or are affiliated with other health or social service agencies.

The Congress has repeatedly emphasized services for the elderly

Since 1963, the Congress has placed a series of requirements and incentives in the CMHC program to encourage the development of comprehensive mental health services. During the 1970s, the Congress moved toward a policy of targeting programs for specific population groups. In 1975, it mandated that specialized services for the elderly be provided by all newly funded CMHCs. The 1978

amendments to the Community Mental Health Centers Act relaxed the timetable for implementing special services, but reemphasized the requirement.

In 1980, recognizing the limited success of previous mandates, the Congress increased the incentives for CMHCs to develop and provide services for the elderly through the Mental Health Systems Act. Separate staffing and coordination grants were to be made available for developing services for the elderly. To obtain these grants, a CMHC would have to identify services specifically designed for elderly clients. The Systems Act was not implemented because of the enactment of the mental health and substance abuse block grant as part of the Omnibus Budget and Reconciliation Act of 1981.

The block grant legislation transferred the CMHC program administration to the States, but it continued the requirements for providing specialized mental health services for the elderly. CMHCs receiving Federal block grant funds from the States are still required to provide specialized outpatient services for the elderly. However, a requirement to provide other specialized services for the elderly similar to that in the Systems Act was not included. Still, the Congress did include language to require that for the next 3 fiscal years States must agree to use most 1/ of the block grant mental health funds for specific activities, including the "identification and assessment of mentally ill elderly individuals and provision of appropriate service to such individuals," and services for chronically mentally ill individuals.

ELDERLY REMAIN UNDERSERVED BY CMHCS DESPITE LEGISLATIVE EMPHASIS

Experts agree that the incidence of mental health problems among older persons is higher than that of the general population. The Task Panel on the Elderly of the President's Commission on Mental Health reported in 1978 that an estimated 15 to 25 percent of older persons have significant mental health problems. Including a portion of elderly persons in nursing homes, this group could total from about 3.7 million to about 6 million individuals. It might be expected, therefore, that the elderly would be at least proportionately represented among CMHC clients. That is not the case. Instead, according to National Institute of Mental Health (NIMH) data, persons over age 65 continue to make up a far smaller percentage of CMHC caseload than their numbers (25 million, 11 percent of the overall population) would suggest.

1/ 100 percent--FY 82.
95 percent--FY 83.
85 percent--FY 84.

Percent of New CMHC Clients Over Age 65 a/

1969	1970	1971	1972	1973	1974	1975	1976	1977	1978
4.0	3.9	3.5	3.8	3.8	3.8	4.0	3.9	4.0	4.3

a/From 1969 to 1978 the proportion aged 65 and over increased from about 10 to 11 percent of the overall U.S. population.

In addition, a 1977 national study showed that, of patients receiving mental health treatment through private psychiatric care, only 2 percent were elderly. 1/

Our work confirms that few CMHC clients are elderly

Our fieldwork revealed similar situations at three CMHCs in New York and Texas. As shown below, at locations visited in those States the reported percentage of elderly clients served in CMHCs for fiscal year 1980 was substantially lower than their representation in the overall population.

Elderly as Percentage of Total Population and CMHC Workload

Location	Percent of population 65+	Percent of FY 1980 CMHC workload 65+
New York:	12.0	(a)
Buffalo General Hospital Community Mental Health Center	11.3	6.0
Orange County Community Mental Health Center	11.0	b/2.1
Texas:	9.7	5.9
Central Texas Mental Health Mental Retardation Center	22.0	7.3

a/Statewide data for fiscal year 1980 were not available for New York.

b/Data are for the period January through December 1979.

None of the centers we visited had waiting lists of elderly clients or other evidence of unmet demand for services. Persons of all ages who came to the center seeking service were accommodated

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1/Butler and Lewis, "Aging and Mental Health," 1977.

quickly. For reasons discussed in chapter 3, however, older persons with mental health problems are less likely than younger individuals to actively seek services.

Reasons offered by the CMHCs for not placing more emphasis on reaching the elderly varied. At one New York center, administrators seemed unaware of requirements to develop and provide specialized services for the elderly. At another CMHC in New York, an official said he had worked with other local agencies to establish a geriatric task force, but little had resulted from the meetings. A Texas CMHC executive director and his staff told us that children's programs were given higher priority because treatment of youths can prevent future mental health problems. It is understandable that center officials want to develop an effective program for children; however, in an earlier site visit, a Department of Health and Human Services (HHS) review team had recommended that the center place special emphasis on services for the elderly due to the large proportion of older persons (22 percent) residing in the area.

MENTAL PROBLEMS OF NURSING HOME RESIDENTS REMAIN UNRECOGNIZED AND UNTREATED

Like their counterparts in the community, mentally ill older persons in nursing homes are also underserved. Because confused or mentally ill patients require more supervision and frequently must rely on Medicaid to pay for their care, they are often the patients of last choice. Even so, according to NIMH data, many nursing home residents (most of whom are elderly) have mental health problems. Often their mental conditions remain undiagnosed because nursing homes are not equipped and have little incentive to provide mental health diagnosis or treatment. Left undiagnosed and untreated, mentally ill nursing home residents have limited prospects for improvement, and their overall conditions may decline more rapidly and ultimately place greater demands on the health care system.

A high proportion of elderly nursing home residents have significant mental problems

NIMH estimates that 750,000 nursing home residents have either recognizable mental illnesses or conditions commonly referred to as senility. Mental illness is the primary diagnosis for about one-third of those patients. An estimated 21 percent of all elderly persons with mental disorders are in nursing homes. However, obtaining a precise count of the number of elderly nursing home residents with mental disorders is difficult because sophisticated mental diagnoses are rare and because most of these patients have multiple interactive illnesses, including both physical and mental problems.

That so many mentally ill elderly are now in nursing homes can be attributed to (1) the deinstitutionalization of individuals from State psychiatric hospitals, (2) the fact that many elderly have developed deteriorating physical ailments in addition to their mental problems, and (3) the availability of Federal reimbursement for long-term care through Medicare and Medicaid.

Administrators of six Medicaid-certified nursing homes located in or near two of the mental health catchment areas we visited acknowledged that mental illness among their elderly patients was widespread. However, they noted that the actual number of mentally ill patients in each facility varied according to its admission policies. These policies depended to a large extent on (1) whether the home was public or private, (2) staff capabilities for dealing with mentally ill patients, and (3) local availability of nursing home beds. For example, the administrator of a large county nursing home said that since it is a public facility it must accept patients that other homes turn away. In addition, because it had some psychiatric services available, it was willing to accept mentally ill patients. Like most nursing homes in Western New York State, the county facility was full and had a waiting list. A study the home had performed of the 745 patients on its waiting list showed that 625 (84 percent) were mentally ill. According to the director, many of those waiting were in more expensive beds in the psychiatric wards of general hospitals or other acute care facilities.

Administrators of two nearby private nursing homes, on the other hand, explained that, since their staffs were not trained to handle mentally ill patients, they did not accept them. However, even at these institutions, by reviewing patient records, we identified patients with mental disorders including both depression and dementias. 1/

1/Common mental disorders which the elderly suffer include:

1. Acute anxiety and depression resulting from transitional life crises, such as retirement or loss of a spouse.

2. Traditional mental illnesses such as chronic depression, schizophrenia, or paranoid states.

3. Deliria and dementias, often called senility, including true senile dementia, such as Alzheimer's disease and the so-called "pseudo dementias" caused by depression, malnutrition, overmedication, etc.

Characteristics of patients with mental problems

Patients with mental problems in the nursing homes we visited fall into three categories:

--older persons who were considered chronically mentally ill, most of whom had a history of treatment in State hospitals.

--Patients who entered the nursing home from the community because of their mental problems, often in concert with physical ailments.

--Patients who had become mentally disturbed after entering the home.

The chronic (deinstitutionalized) mental patients differed from those entering from the community. Chronic patients were likely to be single or divorced and to have no contacts in the community where the nursing home was located. Patients entering from the community, on the other hand, were often married or widowed, and many had family or friends nearby. Women outnumbered men two to one, but there was a slightly higher proportion of men in the chronic group.

The numbers of deinstitutionalized ex-mental patients at each home varied. For example, almost all of the residents of one home in Texas had been released from a nearby State hospital, but at another home, only 3 of a sample of 23 patients had been in a psychiatric hospital.

New York

In Buffalo we reviewed records at one skilled nursing facility (SNF), one intermediate care facility (ICF), and one multilevel county operated home (SNF/ICF). We did not attempt to identify or count all the patients with mental problems. Rather, we looked only for residents whose mental problems were a major factor in their nursing home placement.

Of the 617 SNF and ICF patients in the county home on June 30, 1981, 165 had a diagnosis of organic brain syndrome (a general diagnosis indicating organic impairment of intellectual function, mood, or personality). A number of mental problems which affect the elderly, including organic brain syndrome, are often referred to in nonmedical terms as senility. Additionally, 166 other residents had a variety of diagnoses indicating that mental health problems were a major factor in nursing home placement. These two groups did not include all patients with mental problems because we had excluded those with overwhelming physical disabilities, yet they totaled 331, over half the residents in the home.

In the two privately operated New York homes, fewer patients appeared to be placed in the nursing homes primarily because of mental problems. At the ICF they numbered 16 of 160 patients (10 percent) and at the SNF 16 of 80 (20 percent).

Texas

State health officials estimated that as many as 90 percent of nursing home residents have mental health problems. A review of patient records at two ICFs and one SNF/ICF showed that mental problems were prevalent. Many of the patients were deinstitutionalized State psychiatric hospital residents. Patients' mental conditions in all three homes were often diagnosed in vague or general terms.

At one ICF, 33 of the 70 residents were diagnosed by their physicians as having significant mental problems. Of those 33, one-third were former State hospital patients, and about two-thirds had a general diagnosis of chronic brain syndrome (a term indicating an organic brain disorder with symptoms commonly referred to as senility). At the other ICF there were 47 Medicaid patients, all of whom were deinstitutionalized from State hospitals. Again, chronic brain syndrome was the most frequent diagnosis. Similar patients and diagnoses were found at the SNF/ICF, although fewer residents were deinstitutionalized. Out of a sample of 23 patients whose records were reviewed, 18 had mental problems--most frequently indicated as chronic brain syndrome.

MENTAL HEALTH SERVICES AT NURSING HOMES VISITED

Although nursing homes have become a primary health care center for the mentally ill elderly, professionals concerned with their treatment have observed that mental health services are generally not available there. For the most part, our work confirmed this observation. The absence of mental health services can be attributed to the focus on physical illness by medical and nursing professionals, insufficient collaboration between physical health and mental health agencies, and the lack of financial resources to pay for care.

While none of the homes we visited had a comprehensive range of mental health services, each home in New York provided some psychological or psychosocial services. The homes in Texas offered no specific mental health treatment other than medication.

Nursing homes in New York provided some mental health services

At the three nursing homes we visited in New York, most of the available services were provided by outside groups, and the levels of service varied. All three facilities had staff social workers

who provided counseling. They helped patients deal with personal problems, such as deaths of friends or relatives, and problems with family members or roommates. They also met with patients and families to help them adjust to placement in the home and related guilt feelings. Each facility also had rehabilitation programs, including occupational therapy and physiotherapy, and had active socialization and recreation programs.

A psychogeriatric screening and assessment team from the nearby State psychiatric hospital was available to all area long-term care facilities. It consisted of a psychiatrist, psychiatric nurse, and social worker who would evaluate patients upon request. Services provided by the team generally consisted of consulting on approaches to dealing with the patient or adjusting the patient's medication and usually did not include actual treatment.

Satisfaction with the screening team services varied. One administrator characterized followup on former State hospital patients as poor. Officials at all three facilities said that screening team response time was good if a patient exhibited dangerous behavior; however, the team's principal response to emergency calls was to change medication. Administrators also told us it was almost impossible to get the screening team to admit (or readmit) a patient to the State psychiatric hospital. This was apparently due to the fact that New York State is striving to reduce the population in its psychiatric hospitals and that one of the purposes of the screening team is to prevent avoidable admissions. Several nursing home officials told us that, to get one problem ex-mental patient readmitted, they would have to accept three current State hospital patients into the nursing home. This situation contributes to the private home operators' wariness to accept mentally ill patients.

Only the 600-bed county-operated home had substantial direct mental health services available. The county operates six mental health corporations which serve functions similar to CMHCs. One sends a part-time psychiatrist to the nursing home 1 day a week to prescribe and monitor medications and to counsel patients and two part-time psychiatric nurses to provide actual treatment. These services illustrate the kinds of C&E services which can be provided to nursing homes by CMHCs.

Texas homes provided little mental health care

The homes we visited in Texas provided very little psychosocial or mental health care. No direct mental health treatment was available in the homes, and mental diagnoses were often vague or general. There were few rehabilitation, resocialization, or retraining efforts. As in New York, nurses and staff did not have any special mental health training. According to the patient

records we reviewed, psychotropic drugs were used more frequently than in the New York homes we visited, and little mention was made of mental health needs in patient treatment plans.

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The next two chapters discuss what mental health services are needed and consider some of the reasons why the elderly have not received adequate mental health services.

However, certain attributes of aging create specialized mental health needs. As the elderly become more frail they may have limited mobility. Consequently, transportation, outreach, and visits to older persons' homes or residential facilities are important to facilitate access to care.

Because the elderly may have difficulty accepting changes and may sometimes become confused, treatment that minimizes disruption in their lives is beneficial. In addition, physical and mental conditions are frequently interactive, so combined physical and mental assessments are important.

The social and environmental supports available to the elderly often determine their ability to remain in the community and must be considered in planning care and treatment. Also, consultation and training in the management of mental problems should be available to others who serve the elderly in the community.

The following services comprise the essential elements of a basic program for community mental health services for the elderly.

Psychogeriatric assessment

It is widely agreed that comprehensive assessment and development of treatment plans are important. Trained psychogeriatric screening teams should assess the medical, psychological, and social needs of patients, determine the appropriate supportive environment, and develop a treatment plan. This team should be mobile and should have competencies in mental health problems of the elderly.

There was a consensus among professionals we talked to that psychogeriatric assessment, including differential diagnosis (to distinguish medical from emotional causes of symptoms), is important and should be available to all elderly patients with mental symptoms.

Outreach

Outreach to identify and treat those in need is important because the elderly often do not actively seek mental health services. This occurs because of their limited mobility and the stigma and/or fear of visiting mental health centers. Several professionals suggested that existing community networks of health and social service providers, clergy, and volunteers be used for outreach. Also, door-to-door or neighborhood outreach could be performed by elderly peer groups and mutual support groups. The local AAA was suggested as the appropriate entity to coordinate this service, in cooperation with mental health agencies.

Crisis management/emergency services and short-term inpatient care

Crisis management and emergency services are needed to respond to acute illnesses, such as reactive depression or trauma. These services could be provided in a variety of settings, including: CMHC outpatient clinics, day treatment facilities, and hospital emergency rooms (with psychogeriatric consultation available). Overnight holding capacity should be available to allow observation and stabilization of acute conditions.

When acute problems cannot be stabilized immediately, short-term inpatient facilities are necessary. These facilities may be beneficial to permit stabilization or to diagnose mental illness caused by internal disorders, such as organic brain syndrome. These services could be provided in CMHCs, general hospitals, psychiatric facilities, or nursing homes. Some CMHCs have provided this service in the past.

Day treatment/day care

Day treatment can serve two purposes.

1. Rehabilitation--to treat both acute and chronic mental illness through activity therapy and resocialization toward a goal of increased independence in the activities of daily living.

2. Respite--to provide supervision and activities for the confused or the chronically mentally ill who cannot be left alone. This gives family caregivers time away from the demands of care and can help avoid unnecessary or premature institutionalization.

Rehabilitation day treatment is often provided to deinstitutionalized chronically mentally ill persons, while respite day care may be needed for elderly patients with deteriorating brain conditions (senile dementia).

Specialized outpatient treatment

Outpatient treatment denotes a range of counseling and therapy services which enhance quality of life, including: individual and group therapy, reality orientation, activity therapies, and marital and recreational therapy. This short-term outpatient treatment during life transition crises, such as retirement or bereavement, is an important preventive service. Many mental health professionals we spoke with were concerned about problems of overmedication and alcohol abuse among the elderly. Suggested strategies to reduce these problems include public education and better management of medications.

CHAPTER 2

MENTAL HEALTH NEEDS AND SPECIALIZED SERVICES ARE NOT YET FULLY UNDERSTOOD

The recent professional literature suggests that our knowledge of the special mental health characteristics of the elderly is still developing. Like other aspects of the aging process, psychogeriatric illnesses and appropriate treatment strategies are not fully understood. However, knowledge has been gained over the last 2 decades through research, experience in community treatment, and the development of professional competencies related to aging.

In trying to meet the needs of the elderly, local mental health providers have been somewhat hampered by limited knowledge regarding the mental health needs of older individuals in their catchment areas. In addition, many have not had a good understanding of what specialized services they could make available to meet older persons' needs.

NEEDS OF ELDERLY CATCHMENT AREA RESIDENTS HAVE NOT BEEN DEFINED

It is difficult to plan, develop, and evaluate services for a target population without understanding its special characteristics and needs. Assessment of the mental health needs of the elderly in each catchment area was required under the CMHC program, yet little emphasis had been placed on needs assessments. CMHC officials told us that attempts to assess the needs in the local service areas were made infrequently. Instead, reliance was placed upon national statistics and estimates.

Neither CMHC visited in New York had performed a local needs assessment. The Buffalo General Hospital CMHC cited national statistics in its grant application and referred to a County Mental Health Plan. That plan, however, was based only on estimates from the CMHC and other local providers using varying methodologies and did not address the need for services to the elderly. Center officials were unable to support statements about needs and services in their grant applications or to identify resources directed toward the elderly.

Despite extensive deinstitutionalization over the last decade, the Orange County Center had little information on the number of elderly persons released from State psychiatric hospitals to its catchment area. After our visit, center officials began to work with the area agency on aging (AAA) and service providers to get a better assessment of need.

The CMHC we visited in Texas also had little information on the needs of the local elderly. Center officials said they had not completely assessed need, but that (1) individuals in need would be referred because "everyone knows everyone" in a rural area and (2) the center's workload was full, and they did not want to generate clients they could not serve. A center official told us they had surveyed local nursing homes for mental health needs each year; however, there were no records of these surveys. Information about nursing home needs was not translated into improved mental health services for nursing home patients and few of the center clients were nursing home residents. Using local nursing home records, we were able to identify quickly several mentally ill older persons in the catchment area who had been denied admission to nursing homes. These individuals had not been identified or contacted by the center. 1/

SPECIAL SERVICES FOR THE ELDERLY HAVE NOT BEEN DEFINED

Officials at the CMHCs we visited were uncertain what was expected in terms of specialized services for the elderly. The legislation which mandated these services was not specific regarding service components. HHS regulations and program guidelines were also worded generally and gave center officials discretion to establish service components that responded to local needs.

Because of the uncertainty regarding specialized services and because CMHCs will still be required to provide specialized outpatient services for the elderly under the block grant, we sought to determine whether agreement existed among recognized mental health authorities concerning essential components of a mental health services program targeted for the elderly. The following description of services reflects a consensus of needs reported in recent literature and the suggestions and opinions of numerous authorities in mental health and aging.

SPECIALIZED SERVICES FOR THE ELDERLY

The elderly require many of the same mental health services as other age groups. These services include: accurate diagnosis and treatment planning, referral, emergency and crisis management, treatment at the appropriate level in the least restrictive setting, discharge planning, case management for the chronically mentally handicapped, and supportive services.

1/A GAO report entitled "Health Program Needs Assessments Found Inadequate" (HRD-81-63) issued June 15, 1981, concluded that, at the State and local levels, preparing needs assessments was often regarded as a mandatory exercise that had little effect on decisionmaking, and that little benefit was being obtained from the process.

Case management

Professional case management ensures that elderly patients with multiple chronic health and psychosocial problems receive all medical, psychiatric, and social services necessary to maintain or improve their physical and mental condition. Most professionals we consulted believed that case management is important to help the elderly identify and obtain the social services they need, but a few told us it should not be emphasized because it is very expensive.

A range of institutional care, sheltered living and social support services

Elderly persons with mental health problems require different levels of housing and support services. Some patients, in order to remain at home, need relatively small amounts of support: housekeeping, supervision while a relative has to be out of the home, shopping, meal service, some personal care, or nursing care. This may be much more satisfactory and less expensive than full-time placement in an institution. Sometimes, a night companion or home health aide, for a brief period during an illness or when the patient is temporarily confused, may make a critical difference in keeping a patient at home.

Some patients cannot remain at home or live alone. They may be able to live in group housing with staff on call or may require institutions with progressively more care and treatment. To meet this need, a variety of community housing arrangements can be useful, including supervised group homes, foster homes, senior citizen homes, ICFs, SNFs, and State institutions.

In residential facilities and nursing homes, social services and at least psychogeriatric consultation should be available.

Counseling to families of the elderly

Spouses and families provide most care and support for older persons, but they sometimes need counseling on how best to respond to mental or emotional problems. Counseling could be provided at mental health centers, day treatment centers, or other appropriate places. Discharge planning from acute care facilities can help ensure that the elderly will be adequately cared for at home.

Consultation and education

Psychogeriatric consultation should be available to those who serve the elderly in the community. Persons who provide day-to-day services at nutrition sites, homes for the aged, nursing homes,

and senior centers and those concerned with crisis management, such as police, clergy, and emergency medical personnel, could benefit from such a program. Less obvious benefits include increased public awareness, reduced fear and stigma surrounding mental health treatment, and greater opportunities for identification and referral.

Examples of C&E include training nursing home staffs to cope with patients' behavioral problems, consulting with Medicaid agency reviewers during independent professional/medical reviews of nursing home patients, or speaking on reactive depressions before senior citizen groups.

OBSERVATIONS

The mental health needs of local elderly citizens and appropriate responses to those needs were not fully understood or developed in the three mental health catchment areas we visited. Each of the communities had available some of the services described above. What was missing were systematic efforts to develop an accessible, comprehensive range of services targeted to local needs.

Many of the services which the mentally at risk elderly need are social supports, rather than, or in addition to, more traditional mental health interventions. Many professionals we talked with emphasized the importance of active, ongoing coordination and cooperation among primary care, mental health, and social service providers. We did not find such linkages to be well developed.

Even with the need for specialized services for the elderly and their definition established, numerous barriers remain to developing an effective service delivery network. Some of these barriers can be dealt with locally, while others are national in scope. Chapter 3 summarizes the barriers discussed in the literature and adds the perspective of our visits to communities in New York and Texas.

CHAPTER 3

BARRIERS HINDER DELIVERY OF MENTAL HEALTH SERVICES TO THE ELDERLY

In addition to undefined needs and unfamiliarity with service approaches, several other barriers hinder the delivery of mental health services to the elderly. Some, such as provider and client attitudes and lack of interagency coordination, make the delivery of services to individuals in the community difficult. Others, such as the lack of mental health knowledge among medical professionals, more greatly affect older persons residing in nursing homes. The extent of available reimbursement affects the delivery of services to both groups.

COMMUNITY SERVICE BARRIERS INCLUDE ATTITUDES OF SERVICE PROVIDERS AND THE ELDERLY THEMSELVES

Some who have studied mental health services for the elderly suggest that the low number of older persons served stems from conscious or unconscious age discrimination. At a 1980 Senate Special Committee on Aging hearing on mental health services, former U.S. Commision on Civil Rights Chairman Arthur Flemming testified that "* * * the Commission concluded that age discrimination exists in the community mental health centers program." Flemming, himself a former Federal Commissioner on Aging, told Committee members that some administrators believed it was sound policy to concentrate scarce resources on the young and middle aged. The Task Panel on the Elderly of the President's Commission on Mental Health also concluded that service provider attitudes have contributed to an inadequate response to the needs of the elderly.

Our discussions with CMHC officials and program staff did not disclose many special efforts directed toward the elderly. For example, one CMHC executive director told us his center treats the elderly just like anybody else. This was confirmed by the absence of outreach efforts or specialized services, even though the center's funding proposal referred to them. Only about 6 percent of the center's caseload was over age 65.

Officials at another CMHC told us they tended to give higher priority to children because early treatment could prevent future problems. In fact, no program officials at the CMHCs visited indicated they were trying to reach out and find more elderly clients. At the same time, active demand for services (presenting one's self at the CMHC door) is lower among the elderly than other age groups. These conditions result in low numbers of older clients.

Older people's attitudes may keep them away

Before the deinstitutionalization and community care movements began 2 decades ago, mentally ill individuals were often sent away to be cared for in a State psychiatric hospital. Frequently, family members and neighbors did not speak of them while they were "away." Private psychiatric care was limited and available only to those with substantial resources.

Today mental health care is different, but for those who grew up 50 years ago the change may have gone unnoticed. Older persons still associate fear and shame with mental illness, 1/ and that fear is likely to grow if they sense their own mental decline. Because of their fears and a lifetime of self-sufficiency, many older persons are reluctant to ask for help.

Elderly individuals who have watched the mental decline of an older acquaintance may expect to become unhealthy or confused as they age, but the fact is that an older person who experiences mental problems with age is becoming ill, as well as becoming old. Mental decline is not a normal aspect of aging. Today's medical and mental health practitioners are realizing that many types of long misunderstood problems are treatable, arrestable, and in some cases cureable.

As attitudes toward mental health held by those reaching old age change, the reluctance to seek help may diminish. Meanwhile, active efforts will be required to meet the needs of today's older population.

CMHCs HAVE NOT COLLABORATED WITH AREA AGENCIES ON AGING AND OTHER SERVICE PROVIDERS

Many of the services mentally ill persons need are social and not provided by mental health agencies. Yet there has been a lack of coordination between mental health providers and social service agencies. In the past, a mentally ill person cared for in an institutional setting was provided food, shelter, income assistance, medical care, and other supports in the same location. A similar individual trying to obtain services in the community may have to contact a number of agencies, each with its own rules, to

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1/Report of the Task Panel on Mental Health of the Elderly, President's Commission on Mental Health, 1978.

Toward a National Plan for the Chronically Mentally Ill, HHS, December 1980.

obtain some or all of those same services. Even with the assistance of family members or friends, this can often be difficult.

Service providers for older persons have sometimes been hindered by difficulties in reaching their target population. Unlike school children and working adults, the elderly have no one well-defined location where large groups can be located. One strategy that has had some success is for community agencies and service providers to coordinate their activities and share information toward the common goal of improving services.

To facilitate reaching the elderly, local AAAs were created under the Older Americans Act. These organizations are responsible for planning and coordinating social services for the elderly. It might be expected that mental health providers seeking information on older persons, referrals, or access to large groups for screening or education would work intimately with local AAAs, yet none of the centers we visited had close working relationships with nearby AAAs.

For example, one New York CMHC's grant application indicated that the center had a part-time outreach worker provided by the local AAA. This was not the case when we made our visit. AAA officials told us that they had worked with the CMHC several years ago, but the relationship had deteriorated. AAA staff were providing outreach services to some other nearby mental health providers. In the other New York catchment area, the local AAA had contracted with a private organization other than the CMHC to provide mental health services to individuals exhibiting behavioral problems at the AAA's nutrition sites.

Another strategy for improving interagency relationships to improve service delivery is consultation and education. Discussions with CMHC officials and other service providers indicate that little C&E had been directed toward improving agency, community, or family capacity to understand and help older people's mental problems. Overall, C&E was being provided in an ad hoc manner, rather than in a systematic effort to assist needy individuals and organizations. Part of the problem could be the result of overlapping service areas. Mental health catchment areas do not necessarily coincide with local government boundaries, other health service districts, or AAA planning and service areas. Because the agencies deal with differing populations, there may be a lessened sense of a need to cooperate for the same cause.

CMHC relationships with local health agencies were also not well developed. Health and mental health officials we spoke with expressed reluctance to share patient information with other providers because of the sensitive issue of confidentiality. Continuity of care and access to comprehensive services were made more difficult by agencies' reluctance to share patient information or to refer clients to other needed services.

The need for interagency coordination and cooperation is well documented nationally and was confirmed by our visits in New York and Texas. Increased collaboration among mental health agencies, the local AAA, and other service providers would enhance the development of an often recommended, but rarely achieved "system of services."

CHARACTERISTICS OF THE LONG-TERM CARE SYSTEM REDUCE AVAILABILITY OF MENTAL HEALTH SERVICES

Several aspects of America's long-term care system interact to discourage the development of a new, strong focus on the mental health needs of nursing home patients. These barriers include certain aspects of our public financing mechanisms, characteristics of health care providers, and the historical development of nursing homes as medical care institutions.

Nursing homes were primarily designed to augment hospital capability and have traditionally concentrated on physiological ailments. In spite of the increase in patients with mental problems, the system has remained primarily focused on medical care.

The absence of mental health diagnosis capability and the medical care focus often allow the need for mental health treatment to go unrecognized. Because mental problems are often unrecognized, they are often underreported, and there appears to be no pressing need for services in a given facility.

Other factors discourage nursing homes from focusing on mental problems. Private homes, whether for-profit or non-profit, may be particularly sensitive to community pressures and the ability to attract privately paying patients. If a home accepts a large number of patients with mental problems or makes known a special emphasis on mental health care, it may be responding to a genuine community need. At the same time, it may well experience rejection from both the community and the patients.

Several nursing home administrators told us they were concerned about negative attitudes from neighbors and residents' families if the home's reputation became strongly associated with the mentally ill. One administrator had proposed building a new wing for deinstitutionalized State hospital patients which his board of directors disapproved for fear of damaging the home's reputation.

Nursing home operators told us they must also consider the effects on other patients of accepting and treating individuals with mental health problems. Administrators of private homes often cited this as a reason why they try not to accept disturbed patients.

Training of nursing home staffs does not focus on mental health

As patients are cared for in nursing homes, their needs are usually attended to by nurses and aides who have had little mental health training. The administrators, nurses, and aides at all of the homes we visited had little training or experience in mental health or the psychosocial aspects of aging. Except at one home, little or no C&E was being provided by local mental health agencies.

Nurses at all three facilities in New York told us they had received no formal in-service training on how to deal with mentally disturbed patients, and that their previous professional training had not covered this area in detail. Capabilities at the Texas homes were similar.

Medicaid-certified facilities are subject to periodic reviews by the staff of the State Medicaid agencies. These reviews consider the patient's need for nursing care, the treatment plans, and the care given. These reviews, too, are generally performed by personnel without specialized mental health training who concentrate on medical care.

If nursing home staffs and Medicaid reviewers were provided training in mental health diagnosis and care management, they might be able to identify, manage, and treat problem patients more effectively and overall care might improve. This training could be provided by, or through collaboration with, CMHCs, or State or local mental health agencies.

Nursing home administrators told us they would welcome visits and training from local mental health agencies. Nurses and staff were enthusiastic about learning opportunities in a field they knew little about and told us they would welcome suggestions for dealing with difficult patients. We saw C&E being effectively provided to a nursing home by a county mental health agency in New York, but we saw other instances where C&E could have been provided, but was not. Some improvement in mental health awareness and services could result from closer collaboration between nursing homes and mental health providers. As a first step, nursing home administrators may find it fruitful to assess their consultation and/or training needs and contact a local CMHC or mental health provider.

MENTAL HEALTH COVERAGE UNDER MEDICARE AND MEDICAID IS LIMITED

Medicare (title XVIII of the Social Security Act) is a Federal health insurance program for older persons and some persons under 65 who are disabled. Part A covers hospital inpatient care, certain

skilled nursing care, and home health care, and is funded through Social Security payroll deductions. It covers almost the entire population 65 years of age and over.

Part B is a voluntary, contributory insurance program designed to help pay for outpatient and physician services and medical supplies. Beneficiaries pay a monthly premium, often a deduction from Social Security benefits, which is supplemented by a Federal contribution.

Under both parts, there are certain limitations on services and qualified providers which affect the delivery of community mental health services. For example, some CMHCs and other mental health agencies cannot qualify for provider status because they are not physician-directed clinics. 1/ To be eligible, a physician must be present to perform medical services at all times. Each patient must be under the care of a physician, and nonphysican services must be rendered under medical supervision.

Under both parts there are additional limitations on benefits. Through Part A, hospital inpatient coverage will pay for only 190 days of treatment in a psychiatric facility during the beneficiary's lifetime. Under Part B, outpatient psychiatric service benefits are in effect limited to a maximum of $250 per year. Outpatient mental health services are subject to a 50-percent copayment, rather than the 20-percent copayment for medical treatment. To be covered, these services must be provided under supervision and direction of a physician. Only 4.5 percent of full-time equivalent staff in CMHCs nationwide were psychiatrists or other physicians in 1979.

Medicaid (title XIX of the Social Security Act) is a State-administered public health financing system with partial Federal reimbursement. 2/ Participation and coverage is at each State's option within or outside the broad confines of what the Federal Government will reimburse. Eligibility is generally based on income and resource levels and qualification for other public assistance programs.

To date, 49 States have participated, with wide variation in the services covered. State Medicaid agencies determine who can provide services and what optional services are covered.

1/Toward a National Plan for the Chronically Mentally Ill, HHS, December 1980.

2/The administration has proposed that the Federal Government assume full financial and administrative responsibility for Medicaid in return for the States assuming full responsibility for Aid to Families with Dependent Children.

Services rendered by CMHCs may or may not be covered, depending on the State. When facilities do recognize a need for additional special services or personnel, they may encounter difficulties and delays in getting services approved and, once approved, long delays in reimbursement. For example, in New York, Medicaid reimbursement rates and State-imposed staffing levels were cited by administrators as disincentives to providing additional services. Medicaid rates in New York are set by taking previous facility cost reports, adjusting for inflation, and dividing by the number of patient days. Administrators must demonstrate the need for and benefits of proposed new services, which can take considerable time and effort. Because of the time lag in approvals and rate setting, if a facility adds new services, its costs may not be reflected in the reimbursement rate for up to 3 years.

Nationally, about half of nursing home care for older persons is paid for through public expenditures, principally Medicaid. The remainder is paid through individual and family resources and private insurance. Because of this, Medicaid policies have a large impact on the quantity, quality, and characteristics of available services. These policies provide disincentives to the accurate diagnosis of mental conditions in favor of medically oriented nursing care.

For example, under Medicaid, if a nursing home has over 50 percent patients with a primary diagnois of a mental problem (including diagnoses reflecting senility), the facility would be classified for Medicaid purposes as an institution for mental diseases and would lose Medicaid reimbursement for certain mentally ill patients who were otherwise eligible for reimbursement. 1/ This situation results from a rule imposed when the Medicaid program began, which was to exclude State psychiatric hospitals from coverage. To avoid classification as an institution for mental diseases, homes have incentives to deemphasize the mental problems of patients.

Nursing home administrators told us they prefer patients who pay privately because they usually pay a higher daily rate than Medicaid. Patients whose care is paid for by the Veterans Administration are also preferred because that agency pays a higher rate for 6 months (indefinitely for certain patients), after which the patient is often switched to Medicaid.

1/Title XIX of the Social Security Act does not provide Medicaid benefits to individuals in institutions for mental disease who are between the ages of 21 and 64. Such benefits are available to eligible individuals under age 21 and to eligible individuals age 65 and over whose Medicare benefits are exhausted or when they are ineligible for Medicare.

Patients with mental problems, like other potential residents, often must rely upon Medicaid. In addition, they are likely to require more supervision than other patients. A confused resident smoking in bed is a common example of a situation which necessitates extensive supervision. Unusual behavior and poor personal habits which sometimes accompany psychosocial deterioration may detract from the home's ability to attract private paying patients. These factors combine to make patients with mental problems less desirable than patients with medical problems and, therefore, more difficult to place. Mental health and long-term care officials in New York State were considering the feasibility of paying a premium rate for a period of time for each former mental patient.

Preference may be less of a problem in States with lower occupancy rates. Rather than operate with empty beds, homes have an economic incentive to accept the more difficult patients. This may in part account for the higher numbers of deinstitutionalized patients we observed at the homes in Texas. About 16 percent of Texas nursing home residents were former State hospital inpatients, compared to about 8 percent nationally.

OBSERVATIONS

Some of the barriers to improved service delivery are related to public attitudes and behaviors toward aging and mental illness. To the extent that service development would result from increased public understanding and properly channeled demand, some improvement could be gained through public education and through increased interagency cooperation.

Implicit in several of the barriers to service improvement is the question of financing. Developing new and better services for a target population generally results in increased costs.

CHAPTER 4

OBJECTIVES, SCOPE, AND METHODOLOGY

In January 1981, we began a study in two States of the availability and adequacy of mental health services provided to elderly citizens residing in the community. The principal activity examined was specialized services for the elderly, provided by federally funded CMHCs. Although we had planned to review services in communities nationwide, when the CMHC program was consolidated into a block grant, further study was deferred.

Because only the preliminary study was completed, this staff study is based on limited fieldwork. We interviewed Federal program officials at NIMH and at HHS regional offices, and met with nationally recognized authorities in the field of aging and mental health to discuss the needs of the elderly population, and CMHC efforts to meet those needs. We also met with New York and Texas officials responsible for State mental health programs and long-term care to discuss the particular characteristics of services in their States. In addition, we visited three mental health catchment areas in those States to examine the specific approaches used by CMHCs to meet the needs of the elderly.

New York and Texas were selected for the preliminary study because each had a large elderly population and each received a substantial amount of CMHC funds. In New York, 2,115,000 persons (12 percent of the population) were age 65 or over in 1979, while in Texas there were 1,302,000 elderly individuals (9.7 percent of the population). New York received $11.8 million in Federal CMHC funds in fiscal year 1981 to fund 24 centers and $9.4 million was allocated to 30 Texas centers.

The three CMHCs were selected to obtain urban, suburban, and rural mental health catchment areas with high proportions of older persons. The centers visited were:

--The Buffalo General Hospital Community Mental Health Center which is responsible for about 200,000 people in one of six catchment areas in Buffalo, New York. The center serves about one-fifth of the 1 million population of Erie County, about 11.3 percent of whom are over 65. This is the only center in Erie County which received Federal CMHC funds.

--The Orange County Community Mental Health Center in Newburgh, New York, which serves a mostly suburban catchment area with 11 percent of its population over 65.

--The Central Texas Mental Health-Mental Retardation Center, which serves an expansive rural area. The center covered a 7,000-square-mile area with only 90,000 residents, 22 percent of whom are 65 plus.

In each of the States and catchment areas visited, we met with local health and social service agencies and nursing homes which served the elderly population.

NURSING HOMES

We visited six Medicaid-certified nursing homes in or near Buffalo, New York, and in the rural Texas mental health catchment areas discussed above. We reviewed the nursing home population because the literature indicated that large numbers of mentally ill older persons were using the long-term care system and because nursing home care is financed largely through public expenditures.

The nursing home visits were undertaken to determine the needs and characteristics of mentally ill residents and to identify what mental health services were available. At each home, we interviewed administrators and staff, and our mental health consultant reviewed patient records and treatment plans. We did not attempt to identify all residents with mental health needs, but rather reviewed the records of a sample of patients whose diagnoses and symptoms indicated that their mental status was a major reason for their nursing home placement. At the same time, our consultant attempted to identify patients who might be candidates for return to their homes or to a lesser level of care.

In addition to indepth visits to the six nursing homes discussed above, we made shorter visits to seven other nursing homes in New York, Texas, and the Washington, D.C. area. At these homes, we interviewed administrators and staff, but did not review patient records. We also met with representatives of State and local nursing home associations.

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