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## Mental Health Services

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Phil, a 78-year-old widower, lived independently until about 6 months ago. At that time, he realized that he no longer could get around without the help of a walker. Just as he was accepting this restriction, his eye doctor told him that nothing more could be done to treat his macular degeneration. Now, Phil is legally blind. Because of his independent nature, the eye specialist referred him to a rehabilitation counselor for persons with visual impairments. Despite progress on learning new skills, the counselor became increasingly concerned about Phil's extreme mood swings from anger to despondency. The rehabilitation counselor referred him to the mental health center's peer counseling program. After a few weeks of talking one-on-one with the peer counselor, Phil agreed to participate twice per week in a group of other older adults with similar experiences. Phil likes the idea of talking through his problems with someone his own age. He says, "I am getting the help I need without people thinking I am crazy."

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**A**pproximately 532,000 community-dwelling older adults have a serious or chronic mental illness (e.g., any psychiatric disorder present during the past year that seriously interferes with one or more aspects of daily life) that they have coped with throughout their adult lives (Barker et al., 1992). For other older adults, like Phil, factors such as a decline in physical health, loss of independence, lower socioeconomic status, multiple stressful life events, and limited social support seriously influence their mental health status for the first time in their lives.

This chapter focuses on mental health services for older adults and their families. We begin by examining federal support for mental health programs and services. Next, we profile older adults with mental health problems and describe the various types of programs designed specifically to address their needs. We conclude this part of the chapter with a discussion of the current

and future issues in delivering mental health programs. The second part of the chapter examines mental health services targeted to caregivers of elders with physical and/or cognitive impairments.

## **Policy Background**

The Community Mental Health Act of 1963 created a major change in the provision of mental health services in the United States. It changed the focus of care from long-term, custodial, institutional care in state hospitals to active, outpatient, community-based care. A major goal of outpatient care for all individuals, including older adults, is to encourage maximum independence. This translates into the need for mental health programs and services aimed at keeping older persons within their own homes and communities.

Mental health services for older adults constitute only about 2.5% of Medicare expenditures. Medicare coverage for mental health services was expanded in 1990 (via the Omnibus Budget Reconciliation Act [OBRA] of 1989), but coverage of specialized services is still limited. For example, although there is no limit on the total number of hospitalization or inpatient days for psychiatric care in general hospitals, coverage for inpatient care in freestanding psychiatric hospitals is limited to 190 days during an individual's lifetime. For outpatient services, there is no limit on allowable charges, although there is a 50% coinsurance. OBRA (1989) also expanded the coverage for services provided by nonphysician providers. Psychologists and clinical social workers rendering mental health services now are eligible for direct reimbursement; previously, reimbursement was made only when the services provided by these professionals were under the direct supervision of a physician.

In response to the changes put forth by OBRA, the National Association of Insurance Commissioners revised the model Medicare Supplemental (Medigap) insurance regulations. All Medigap policies are now required to cover the 50% coinsurance for outpatient mental health care under Medicare Part B (Finkel, 1993). Unfortunately, this change is prospective, therefore it does not apply to older adults holding Medigap policies in effect prior to their state's adoption of the new model regulation.

Medicaid services for mental health care for older adults vary substantially among states. Coverage is divided into mandatory and optional services (Taube, Goldman, & Salkever, 1990). General hospital inpatient care, physician services, outpatient services in general hospitals, emergency room services, and nursing home care are mandatory. These services focus on the needs of patients with acute illness episodes and persons who need to be in a nursing home. The optional services help persons with chronic mental impairments living in community settings. These services include care by

nonphysicians, freestanding outpatient clinics, case management, rehabilitation, and home health care. Many states have not adopted Medicaid's optional elements. In those states that have, providers are often reluctant to participate because of the low rates of reimbursement.

In 1987, the Omnibus Budget Reconciliation Act was passed by Congress as part of Medicaid reform. This legislation requires that all prospective nursing home applicants who have a primary or secondary diagnosis of a major mental disorder undergo a preadmission screening to determine if they are appropriate for nursing home admission and if they need active treatment for mental illness. The mental disorders covered by OBRA include schizophrenia, paranoid disorders, major affective disorders, schizo-affective disorders, and atypical psychoses. Nursing homes who admit older adults with designated psychiatric conditions without conducting the prescreening are denied Medicaid payments.

The Social Security Administration administers several programs that provide cash payments or other benefits to persons with mental disabilities. Persons with adequate work histories usually receive monthly cash payments as Social Security benefits, and persons with minimal resources and insufficient work history usually receive a monthly payment under the Supplemental Security Income (SSI) program. Approximately 46,000 persons 65 years of age and older receive government disability payments because of their mental disorders (Barker et al., 1992).

Older American Act funds also may be used to support mental health services for older adults under Title III-B and III-F. Title III-B, which allocates spending for a wide range of supportive services, includes funding for mental health programs as well. Local AAA funds can be used to support mental health programs and services designed to enable older adults to attain and maintain mental well-being. Funding also may be authorized under Title III-F, which funds disease prevention and health promotion services. Health promotion services can include screening for the prevention of depression, coordination of community mental health services, provision of educational activities, and referral to psychiatric and psychological services. Thus, local AAAs have the opportunity to fund a wide variety of mental health programs and services under the OAA.

## **Users and Programs**

### **Characteristics of Mental Health Clients**

Between 15% and 25% of people 65 and older are purported to suffer from mental illness or emotional distress that affects their quality of life (Buckwalter,

Smith, & Caston, 1994). Approximately 60% of the mental health problems experienced by older adults are due to nonorganic psychiatric disorders (e.g., affective and anxiety disorders), with the remaining due to organic mental disorders (i.e., dementia; George, Blazer, Winfield-Laird, Leaf, & Fischbach, 1988).

Depression is the most common reason for referring older persons for mental health services (Kent, 1990; Mosher-Ashley, 1993). As many as 15% of community-dwelling older adults and 50% of elders living in long-term care facilities suffer from depression (Blazer, 1989). In the majority of cases, their depression is viewed as a reactive depression (i.e., the person is reacting to a major life loss or transition) rather than as stemming from other etiologies. Other reasons older adults are referred for mental health services include (a) Alzheimer's disease and other organic mental disorders, affecting approximately 10% of individuals 65 years of age and older living in the community; (b) suicide behaviors—17% of all suicides are committed by adults 65 years of age and older; and (c) alcoholism, which affects about 10% to 15% of older adults, the same rate as found in the general population (Ostrander, 1992). Greater percentages of older adults of color (i.e., African Americans, Hispanics, American Indians, and Asian-Pacific Islanders) report having mental health problems than do their white counterparts. Within these minority groups, women tend to have higher rates of affective and anxiety disorders, whereas men tend to have higher rates of substance abuse-dependence disorders (Stanford & Bois, 1992).

Several demographic variables are associated with the use of mental health services among older adults (Freiman, Cunningham, & Cornelius, 1993). For example, increasing age is associated with a lower probability of mental health, as is being a person of color. Women and individuals recently widowed have a significantly higher probability of health care use for mental problems than do men and married persons. Also, the more acute and chronic health problems reported by older adults, the more likely they are to be using mental health services.

Only about 5% of rural community mental health centers' patients and less than 2% of rural private patients with psychiatric problems are older adults (Buckwalter et al., 1994). Buckwalter et al. suggest several factors that adversely influence the appropriate use of mental health services by rural elders, including sociodemographic, economic, and cultural issues; the lack of mental health professionals to work with aged individuals; and the stigma surrounding mental illness and its treatment.

Older adults with serious or chronic mental illness represent the most severely disabled persons with psychiatric disorders, yet there is almost no research concerning the use of community services by these individuals (George, 1992). One study of 111 deinstitutionalized older adults with

chronic mental illnesses revealed that those individuals receiving care and support from family members were most likely to be living in the community (Meeks et al., 1990). Among these individuals, 59% were on psychotropic medications, but only 17% were seeing a mental health professional on a regular basis.

Residents of long-term care facilities also benefit from mental health services. The three major nursing home resident groups needing such services are persons who are physically ill but cognitively capable; persons who are mentally ill but cognitively capable; and those with dementia. Although different therapeutic issues arise and different interventions are needed for each group, all long-term care residents face similar situations in which they may require emotional support, including (a) making the transition into the facility, (b) establishing relationships with staff, (c) adapting to the institution's schedule, (d) adjusting to new roles with family caregivers or to a lack of family caregivers, and (e) accommodating to a new activities schedule (Lichtenberg, 1994). Unfortunately, results of a national survey revealed that less than 5% of older nursing home residents have contact with a mental health professional or receive some type of mental health care from a general physician (Burns et al., 1993). Those receiving mental health services were more likely to have a specific mental health diagnosis, were exhibiting mood disturbances, and had been transferred from a psychiatric hospital. This suggests that services are more likely to be directed toward individuals with more severe impairments. In addition, age was a factor. Individuals between the ages of 64 and 74 were more likely than older patients to receive care.

### **Mental Health Programs**

For most older adults, mental health intervention does not mean going into a counselor's office or receiving help from a specialized mental health care center. Fewer than 2% of persons seen in private psychiatric offices and only 4% to 6% of patients who receive community mental health services are 65 years of age and older (Wykle, Segall, & Nagley, 1992). This can be attributed to several factors: (a) Most centers are not widely accessible and tend to be isolated from the mainstream of community health and social services for older adults; (b) mental health service programs have not aggressively engaged in outreach and case finding; rather, they tend to rely on referrals and self-identification of potential clients; and (c) reimbursement for treatment of mental disorders under Medicare is substantially less complete than for physical disorders (Lebowitz & Niederehe, 1992).

The aging service network provides a wide range of mental health services for older adults. The results of a national mail survey of AAAs (Bane, Rathbone-McCuan, & Galliher, 1994) indicate that the most common services

available in rural planning and service areas (PSAs) were telephone reassurance, mental health screening, individual counseling, and Alzheimer's support groups. In mixed PSAs (i.e., areas with rural, urban, and suburban counties) the most common mental health services were Alzheimer's support groups, counseling, and mental health referral and materials. Great variability in the community resources that facilitate these services to older adults was found in both the rural and mixed PSAs. For example, more than 80% of respondents in both areas reported the availability of adult protective service intervention for older persons with mental health problems, whereas only 12% of the rural PSAs and 31% of the mixed PSAs reported having a mobile mental health team that traveled to the person's home.

Mental health services and counseling may take place in a health care setting (i.e., physician office or clinic), the client's residence (i.e., own home or nursing home), a senior center, or an adult day center. For example, more than 350 persons 55 years of age and older have participated in a counseling program located at *Mature Minglers* multipurpose senior center in Michigan (Grady, 1990). The *Geriatric Service Program* located in Baltimore County provides psychotherapy sessions at the suburban homes of older adults unable or unwilling to come to a senior center, where services are also provided, or to the community mental health center in which the program is housed (DeRenzo et al., 1991). The *Senior Adult Growth and Enrichment Program* in North Carolina is a mental health outreach program that provides home-based services to rural older adults living in their own homes or in long-term care facilities (Atkinson & Stuck, 1991).

Relatively little is known about the community-based services available to older adults with serious or chronic mental illness who are at risk for or who have a history of psychiatric hospitalization. A nationwide survey of 73 mental health agencies providing outpatient psychiatric services to this group of older adults provides some descriptive information about the services provided and the problems facing agencies serving older adults with chronic mental illness (Mosher-Ashley & Allard, 1993). The majority of agencies surveyed were community mental health centers (87%). The primary services provided to older adults with chronic mental illness were counseling, crisis intervention, case management, group therapy, case consultation, in-service training, and day treatment. The most common problems agencies faced in providing services to older clients with chronic mental illness were insufficient funds, lack of residential services, lack of transportation, and insufficient staffing.

Although community-based treatment of older adults with mental health problems is preferred by both older adults and mental health professionals, a small proportion of older individuals need more intensive care provided by institutions. Persons older than age 65 represent less than 7% of all individuals

**Best Practice Gatekeeper Program**

This program, originally developed in 1978 in Spokane County, Washington, is designed to seek out and offer assistance to at-risk older adults living in isolation. This is accomplished through “gatekeepers,” nontraditional referral sources such as postal workers, meter readers, phone operators, and others who come into contact with older adults on a regular basis. Gatekeepers are trained to identify and refer at-risk older adults to appropriate support agencies that can intervene and solve a problem before it becomes a major crisis.

For more information about the Gatekeeper Program, contact Elderly Services Program, Spokane Community Mental Health Center, 107 South Division, Spokane, WA 99202, 509-458-7450.

SOURCE: American Association of Retired Persons (1996).

receiving inpatient psychiatric services. Symptoms of depression, anxiety, dementia, paranoia, delusional ideation, and alcohol and drug abuse are the most likely reasons for admission of older persons to psychiatric hospitals. The need for hospitalization is dependent on the severity of symptoms and the older person’s ability to carry out activities of daily living. In addition, patients frequently have concomitant physical illnesses that also must be addressed. The major goal of residential treatment programs is to alleviate symptoms and provide care and training in skills of daily living (Wykle et al., 1992).

The number of specifically trained individuals to provide mental health services targeted for geriatric patients is small but growing. Four major clusters of professionals treat older adults: psychiatric nurses, clinical social workers, psychologists, and psychiatrists (Gottlieb, 1990). They work in settings such as community mental health centers, inpatient settings, HMOs, public and private agencies, hospitals, nursing homes, and private practice. Mental health services for older adults may also be provided by physicians certified in geriatric medicine, counselors and therapists, and pastoral counselors.

The last 15 years have seen a growth in the use of paraprofessionals providing psychological and psychosocial interventions with older adults (Lichtenberg, 1994). In some cases, they offer formal mental health services, whereas in others, they provide informal support. Paraprofessionals work alone or in conjunction with or under the supervision of trained professionals. One type of paraprofessional program that has grown rapidly during the last two decades is peer counseling programs for older adults. These programs train and supervise older adults to provide counseling and support to other older individuals. Peer counselors typically address a broad range of issues including depression; loneliness; problems that result from physical

impairments; and other concerns related to aging, gender, and ethnicity. They receive supervision from a professional counselor employed by the agency sponsoring the program. Programs often begin because they are a cost-effective means of providing mental health services for older adults. The benefits of peer counseling programs for older adults include these: (a) Many older people talk more readily to older people than to professional therapists; (b) peer counselors serve as positive models for their clients; (c) peer counseling enriches the lives of both the client and the counselor; and (d) peer counselors may be more effective than professionals because they are often more aware of the problems indicative of the older individual (Bratter & Freeman, 1990).

## **Challenges for Mental Health Programs**

The graying of America and the deinstitutionalization of persons with mental illness have resulted in increased attention to the mental health needs of older adults. Although great improvements in the delivery of mental health services have been made since the passage of the Community Mental Health Act in 1963 and the funding of mental health programs under the OAA, many challenges remain to improve the delivery of mental health services to older adults.

### **Connecting the Delivery Systems**

The two primary systems involved in providing community services to older adults with mental health concerns are the public mental health system (primarily community mental health centers) and the aging service network. A formal relationship between community mental health centers and the aging network, however, often is the exception, rather than the rule. This is unfortunate for older adults because those centers with formal relationships with local AAAs tend to provide a larger range of services to older adults, provide services to older adults in more settings, and provide mental services to higher proportions of older adults than do those without formal affiliations (Lebowitz, Light, & Bailey, 1987). Thus, joining forces appears to be the most effective and efficient means of reaching and servicing older adults with mental health concerns.

### **Reaching Diverse Groups**

Older adults of color use mental health services to a lesser extent than their white counterparts, yet they appear to have the same, if not greater, need for



such services. Use is affected by language barriers, limited access to information regarding available services, transportation, cultural dissimilarity, and reduced social and economic resources (Stanford & Bois, 1992). Because individuals from ethnic minority groups represent a rapidly increasing segment of the total older adult population, mental health services must recognize the importance of cultural sensitivity and cross-cultural training of mental health professionals as one means of eliminating the barriers to use of mental health services by ethnic minority elders.

The rural older adult population also is vastly underserved by the mental health system (Bane et al., 1994; Buckwalter, Smith, Zevenbergen, & Russell, 1991). As with most other service sectors, rural providers are faced with the issues of availability, accessibility, and acceptability of mental health services. In addition, the closure of rural physician practices and hospitals has forced rural citizens either to use local emergency services, regardless of whether they are capable of responding to mental health problems, or to seek health care in distant urban areas (U.S. Congress, Office of Technology Assessment, 1990).

### **Training Providers**

Needed are more providers trained specifically to address the mental health concerns of older adults. By the year 2020, as many as 500 additional academic geriatric psychiatrists will be needed to offer leadership in education, training and research in this area (Committee on Personnel for Health Needs of the Elderly, 1988). Similar needs are projected for the other specialities constituting the core disciplines of geriatric mental health—psychology, social work, and psychiatric nursing. Continuing education programs also are needed for current mental health practitioners, many of whom lack the knowledge and skills necessary to effectively work with older adults needing mental health services.

### **Providing Mental Health Programs in the Future**

The 1995 White House Conference on Aging gave specific support for programs that meet the mental health needs of older adults. Delegates passed 14 resolutions that supported policies related to mental health, including those to (a) amend Medicaid to include provisions that ensured the availability of home and community-based mental health services; (b) amend all statutes that regulate public and private health and long-term care insurance plans to achieve parity in coverage and reimbursement for mental and physical health disorders; and (c) expand educational and training programs in mental health and aging for professionals as well as for older persons, their families, and other gatekeepers in the community.

Because the vast majority of older adults exist in and interact with a family network, the mental health needs of those within the family network must be addressed. We now turn our attention to the mental health needs of family caregivers.

## **Mental Health Services for Family Caregivers**

One potential consequence of providing care for older adults with physical and cognitive impairments is an increased risk of mental health problems among family caregivers. Caregivers are highly vulnerable to stress-related physical and emotional complaints. They frequently report experiencing bouts of depression and a high use of psychotropic drugs (George, 1992). Community services for caregivers include educational programs, support groups, respite care, and assistance with handling their emotional reactions to the changes in their loved ones. These services may be partially funded or supported by various state, local, and nonprofit voluntary agencies. In this section, we describe the characteristics of caregivers who use mental health services and the types of services available to them. We end with a discussion of the challenges facing programs trying to reach and serve these caregivers.

### **Users and Programs**

#### **Characteristics of Caregivers Using Mental Health Programs**

Family caregivers who seek support from mental health professionals present a wide array of problems and concerns. A study of 51 family caregivers who participated in weekly individual counseling sessions revealed nine pressing issues and problems: improving coping skills (time management, dealing with stress, and other coping mechanisms); family issues regarding spouse, siblings, and children; responding to the older person's emotional and behavior needs; physical well-being and safety; legal and financial affairs; quality of relationship with the care receiver; eliciting formal and informal support; feelings of guilt and inadequacy; and long-term planning (Smith, Smith, & Toseland, 1991). These problems and issues are consistent with findings of other researchers and suggest areas in which practitioners need to be prepared to help caregivers with a broad range of problems and concerns.

Group interventions also provide caregivers with skills and support to cope with the stressors of caregiving. An extensive review of the caregiver support group literature (Toseland & Rossiter, 1989) revealed that the typical

support group is composed of predominantly middle-class women, mostly the wives and daughters of those receiving care. Although participants range in age from 16 to 80, most are between the ages of 40 and 65. The majority provide care for a parent or relative with some form of mental impairment.

### **Mental Health Programs for Family Caregivers**

Programs designed to meet the mental health needs of family caregivers include individual counseling, support groups, and educational programs. A review of these intervention strategies suggests positive outcomes for the caregivers who participate (Gallagher-Thompson, 1994). With respect to individual counseling, spouses of persons with Alzheimer's disease report less depression after their participation in brief psychodynamic psychotherapy. This approach offered caregivers the opportunity to understand how past conflicts were influencing their reactions and responses to their current situation (Rose & DelMaestro, 1990). After completion of brief cognitive-behavioral therapy whereby participants were taught to identify and modify the negative thoughts that contributed to the development and maintenance of depression, caregivers reported a significant reduction in symptoms associated with depression (Gallagher-Thompson, 1994). Behavioral therapy approaches also are effective in teaching management skills to family caregivers of persons with dementia, thereby reducing the stressfulness of the situation for the caregivers (Fisher & Carstensen, 1990). A study of individual counseling for daughters and daughters-in-law who were primary caregivers for physically frail elders also revealed positive outcomes for those who received treatment, compared with a no-treatment group (Toseland & Smith, 1990). Caregivers participating in counseling demonstrated more effective coping skills, improved psychological well-being, and improved relationships with the care receivers than did caregivers who did not receive counseling.

Support groups, a popular form of caregiver intervention, are widely available and generally well attended (Gallagher-Thompson, 1994). Most groups are limited to six to eight sessions. Almost all include both education and support, focusing on seven major themes: information about the care receiver's situation, the group and its members as a mutual support system, the emotional impact of caregiving, self-care, problematic interpersonal relationships, the development and use of support systems outside the group, and home care skills. The majority of leaders report positive outcomes for regular attendees, and the participants report high satisfaction with the group. These outcomes, however, tend not to be substantiated by data obtained either through the use of standardized measures in case study evaluations or by more rigorously designed research studies (Toseland & Rossiter, 1989).

For Your Files **Caregiver Support Groups in America**

*Caregiver Support Groups in America*, a new directory published by the National Council on the Aging, lists 750 support groups for caregivers. The caregiver groups are listed state by state and include specific types of support groups such as for children of aging parents or for persons taking care of individuals with Alzheimer's disease. The guide also includes a listing of manuals on how to start a support group. For more information, contact National Council on the Aging Publications, Department 5087, Washington, DC 20061-5087, 202-479-1200.

Numerous educational programs have been developed to meet the needs of individuals faced with the challenges of providing care for frail, aging relatives. Most of these programs are for spouses and adult children who have assumed the primary responsibility for a family member experiencing physical or cognitive decline. The majority of these programs cover a variety of topics including community resources, sensory changes, communication skills, normal aging, behavioral changes, living arrangements, coping with stress, and chronic illness (Roberto, 1990). Among the few program descriptions or evaluations found in family or gerontological journals, several commonalities existed. First, the presentation formats are similar. A two-hour session offered during several weeks is the most popular model. Second, almost all programs use a multiple topic approach. Third, although the majority provided similar content, most programs are designed for a specific target population (Brubaker & Roberto, 1993).

Many cooperative extension programs provide support in meeting the mental health needs of caregivers of frail elders. Through the facilitation of formal educational programs (Epstein & Koenig, 1990) and support groups (Marsden, 1990), family members learn how to more effectively carry out their roles and responsibilities as primary caregivers while reducing feelings of stress and burnout. For example, the *Volunteer Information Provider Program* initially designed to help rural Missouri families deal with the stress of caregiving has been replicated in at least 24 states and the District of Columbia (Halpert & Sharp, 1989). The goal of this program is to train peer volunteer information providers to deliver information to family caregivers on topics such as the normal aging process, communication skills, and stress management.

Since the pioneering efforts of the Travelers Companies in the mid-1980s, workplace support for caregivers has increased (Neal, Chapman, Ingersoll-Dayton, & Emlen, 1993). Employers provide support for their employees with elder care needs through their policies (e.g., job-sharing options; flex-time; and medical, personal, or family leave time), benefits (e.g., insurance,

tax credits, dependent care reimbursement plans, and subsidized care), and services (education, information and referral, counseling, and case management).

### **Challenges for Family Caregiver Mental Health Programs**

As the number of frail older persons increases and more family members occupy the role of caregiver, the emotional support provided by mental health services will be in greater demand. A number of challenges need to be addressed to meet the mental health needs of family caregivers.

#### **Increasing Participation in Programs**

A limited number of caregivers attend mental health-related programs or use services that may enhance their ability to provide care. This may be because many do not identify themselves as caregivers or because they may lack a caregiving alternative that would allow them to attend therapy or other types of programs. When caregivers do access these services, it usually is because they have reached a crisis stage. Health care and other service providers need to inform caregivers of the availability of supportive services and encourage their use before caregivers experience distress. Caregivers need to be continually reminded to “take care of themselves.” They also need reassurance that using services does not mean that they are failing to meet their caregiving responsibilities, but rather that through the use of such services, they are maintaining and enhancing their coping abilities. Employers also need to recognize the benefits of mental health programs for their employees who are family caregivers and make those services available through employee assistance programs.

#### **Reaching Diverse Groups**

Despite research that demonstrates that minority caregivers experience burden and depression, they are less likely to participate in caregiver support programs. The lack of seeking mental health support may be due in part to the caregiver's reliance on others in the informal network for caregiving assistance and the internalization of the caregiver role, which makes seeking formal services contradict strong cultural norms of family responsibility (Cox & Monk, 1993). Because cultural norms may make it difficult for caregivers to turn to the formal network for support, services must be sensitive to the differing personal and cultural expectations held by caregivers of various

ethnic and racial groups. Cox and Monk suggest that support groups need to be created within ethnic communities in which caregivers would feel more comfortable discussing their problems with those who have similar cultural experiences and expectations.

### **Mental Health Programs in the Future**

The delegates of the 1995 White House Conference on Aging endorsed mental health programs that support caregivers of older adults. Specifically, delegates passed resolutions promoting policies that (a) provide culturally, ethnically, and linguistically sensitive education and support for intergenerational family caregivers through the efforts of volunteers and revenue-neutral support groups and (b) expand the Family and Medical Leave Act of 1993 for individuals who render care for aging relatives.



### **CASE STUDY**

#### **SCHIZOPHRENIA COMPLICATES CARE NEEDS**

Katherine is a 77-year-old divorced woman who has a diagnosis of schizophrenia. Although Katherine has most likely been a schizophrenic since her early 20s, she was not formally diagnosed until her mid-50s. Since her diagnosis and subsequent treatment, Katherine has enjoyed long periods when she has felt good. Like many mental health patients, however, when Katherine is feeling good, she stops taking her medicine. Gradually, mood changes occur that escalate to hostile and paranoid behavior. On many occasions, she has had to be hospitalized in the psychiatric care unit of the local hospital. The length of time under such care varies, depending on how long it takes to regulate her medication.

Despite her illness, Katherine raised four sons. Two of her sons are dead, one lives out of state and takes no interest in his mother, and the fourth and youngest son, Tom, lives nearby. Tom tries to help his mother, but it isn't easy. She keeps to herself and does not let people, even her son, get close to her. In her community, she is known as a character who doesn't mince words. Although she is fiercely independent, she is dedicated to her church. One of her favorite rituals is communion, which she always takes twice a year.

Now, age has compounded her problems. Katherine is overweight, is unsteady on her feet, and has arthritis and poor vision. It is increasingly difficult for her to get around. At this stage, her isolated, simple life is also becoming problematic. She requires more services such as transportation, shopping assistance, and daily monitoring to make sure she is taking her medication. Although her disease has leveled out some, she continues to have relapses when she is non-

compliant with her medicine. These events are more frequent than necessary. Both her son Tom and her mental health worker of 3 years are concerned about her future.

### CASE STUDY QUESTIONS

1. What mental health research data discussed in this chapter best describe Katherine?
2. Do you think Katherine's mental health diagnosis, coupled with her physical problems, makes her more at risk of institutionalization? Why or why not?
3. Katherine probably would not qualify for nursing home care as a Medicaid recipient solely because of her physical health. Under what circumstances described in the chapter could Katherine receive nursing home care paid for by Medicaid?
4. Fortunately, Katherine has the services of a professional mental health worker. From which of the mental health programs described in the chapter has Katherine most likely been receiving services?
5. What types of support may be available for Tom to help him understand and care for his mother?



### LEARNING ACTIVITIES

1. Interview a mental health professional who works with older adults. What are some of the primary issues with which many older adults seek or need assistance? What are some of the difficulties in getting older adults to participate in mental health services? Why has this professional decided or been chosen to work with older adults? How might the skills needed be similar to or different from those needed to work with other populations?
2. Ask a mental health service provider to share with you copies of the assessment tools that are used for younger and older adults. Are they similar or different? Would you have difficulty in answering some of the questions?
3. Sit in on a peer counseling or other type of mental health training. What was the topic? How did it relate to older adults, family caregivers, or those providing services to them? What did you learn?
4. What do you believe are the benefits and issues related to mental health services for older adults and their family caregivers? What did you learn were some of the barriers, and what might the agency and the community do to break down the barriers? What might keep you from accessing mental health services currently and in the future?

## FOR MORE INFORMATION

### National Resources

1. National Institute of Mental Health, Information Resources and Inquiries Branch, Room 7C-02, 5600 Fishers Lane, Rockville, MD 20857, 301-443-4513.

The National Institute of Mental Health conducts and supports research to learn more about causes and treatment of mental and emotional disorders. Available are free publications including *Plain Talk About Aging, If You Are Over 65 and Feeling Depressed*, and *Plain Talk About Handling Stress*.

2. National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314-2971, 703-684-5968; National Mental Health Information Center, 800-969-6642.

The National Mental Health Information Center, established by the National Mental Health Association, provides inquirers with information about mental health topics and has a wide variety of written information about mental health topics.

3. Alzheimer's Association, 919 North Michigan Avenue, Suite 1000, Chicago, IL 60611, 800-272-3900 (<http://www.alz.org>).

The Alzheimer's Association sponsors education programs and support services to patients and families who are coping with Alzheimer's disease. The association offers a 24-hour hotline with information about Alzheimer's disease and local chapters and resources. Educational materials are also available.

4. National Self-Help Clearinghouse, 25 West 43rd Street, Room 620, New York, NY 10036, 212-642-2944.

The National Self-Help Clearinghouse collects and distributes information about self-care and self-help groups across the United States and offers such groups technical assistance. Publications and guides to organizing self-help groups are available.

### Web Resources

1. Mental HealthNet  
<http://www.cmhc.com/>

This is quite a site! This site offers more than 4,200 individual resources on mental health issues. Links to a reading room, professional resources, self-help resources, and other mental health Web resources are listed. Definitely worth the visit when you have some time to spend between classes!



2. Psych Central, Dr. John Grohol's Mental Health Page  
<http://www.coil.com/grohol/web.htm>

This psych Web pointer helps visitors locate information on the Web and is organized by topic or alphabetically. There is an incredibly lengthy list of general support resource links to other sites on the Web with a brief description. It's the most comprehensive mental health listing we found.

3. Emotional Support Guide  
<http://asa.ugl.lib.umich.edu/chdocs/support/emotion.html>

This site, created by the University of Michigan Library, has links to emotional support resources, such as Griefnet and Caregiver Information, chronic illness resources, and bereavement resources.