92d Congress, *1st Session* | SENATE | Report No. 92–433

MENTAL HEALTH CARE AND THE ELDERLY: SHORTCOMINGS IN PUBLIC POLICY

A REPORT

BY THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

November 8, 1971.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
69–261 O WASHINGTON : 1971

SPECIAL COMMITTEE ON AGING

FRANK CHURCH, Idaho, *Chairman*

HARRISON A. WILLIAMS, Jr., New Jersey
ALAN BIBLE, Nevada
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
FRANK E. MOSS, Utah
EDWARD M. KENNEDY, Massachusetts
WALTER F. MONDALE, Minnesota
VANCE HARTKE, Indiana
CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri

HIRAM L. FONG, Hawaii
JACK MILLER, Iowa
CLIFFORD P. HANSEN, Wyoming
PAUL J. FANNIN, Arizona
EDWARD J. GURNEY, Florida
WILLIAM B. SAXBE, Ohio
EDWARD W. BROOKE, Massachusetts
CHARLES H. PERCY, Illinois
ROBERT T. STAFFORD, Vermont

WILLIAM E. ORIOL, *Staff Director*
DAVID A. AFFELDT, *Counsel*
JOHN GUY MILLER, *Minority Staff Director*
ROBERT N. BUTLER, M.D., *Consultant for this study*

PREFACE

Mental health care for older Americans has received intensive attention within recent years from government, medical professionals, and scholarly researchers. As a result, some therapies have been markedly improved. Our understanding of the very nature of mental illness in the later years of life has been broadened. Several pilot programs hold out the hope that institutionalization for certain segments of the afflicted elderly can be prevented or reduced.

And yet, 10 years after a White House Conference on Aging at which comprehensive and enlightened recommendations were offered on actions that could be taken in this area, this Senate Committee has been told by well-informed practitioners* and administrators that progress during the past decade has been sporadic and, in some ways, perhaps even retrogressive. In addition, committee inquiry has produced information which tends to confirm the overall impression of limited achievement.

Part of the problem lies in State budgetary crises, with resultant cutbacks in Medicaid.

Part of the problem lies in limited help provided under Medicare and the community mental health program.

Part of the problem lies in widespread misunderstanding about new possibilities for reversing disorders among many elderly patients.

Closely related to all of these problems is one of pessimistic attitudes about the "treatability" of the elderly. It is true that many older persons in institutions are ill physically as well as emotionally. It is true that many need continuing care in those institutions. *But, as has been demonstrated often within recent years, reversibility or marked improvement is possible in a significant number of cases. If such opportunities exist, they should not be denied to patients who happen to be elderly.*

The following report is a brief survey of recent developments which should be of concern to participants in this year's White House Conference and to those who will work to implement the recommendations that will be made at that Conference.

By no means is this document intended to be a definitive treatment of the subject. Instead, it identifies several major problem areas; it deals more with questions than with answers. But the report also makes it clear that those questions should be answered, and they should be answered in the near future.

As its major recommendation, the report calls for establishment of a President's commission which would do far more than merely assemble another array of facts for publication in a soon-forgotten report.

---

*For statements by the American Psychiatric Association, the American Psychological Association, the Group for the Advancement of Psychiatry, and the President's Task Force on Aging (1970), see Appendix 1, p. 152.

Instead, this commission would take advantage of unique opportunities which could make 1972 a year of accomplishment. For one thing, the commission could work directly with those who will be responsible for carrying out recommendations to be made at this year's White House Conference. For another, interest in the subject is high among professional organizations and many individuals who have looked into the subject in conjunction with the White House Conference. And finally, Medicare and Medicaid are under intensive review, caused partially because of demonstrable inadequacies and partially because of the intensifying debate about proposals for a national health insurance program. Given such circumstances, a commission could combine study with action.

This report, in addition to surveying the field and making interim recommendations, also offers—in part 2—several examples of positive steps that have been taken in several States to reduce institutionalization or provide better care. These projects are significant and welcome, but they are serving relatively few persons when compared to total need. Dr. Wilma Donahue, who first suggested to the committee that these programs be evaluated in a report of this kind, describes them in her introduction as "islands of progress" worthy of widespread attention.

In the third part of this report, several individual authors have written papers which comment on matters only briefly described elsewhere. Dr. Robert Butler, who also served as a consultant to this committee in the preparation of this report, voices his special concern about the impact of "age-ism" upon mental health care for the elderly. Dr. Alvin Goldfarb has provided a study which warns against fads and easy solutions in dealing with mental illness among the elderly; he also evaluates the projects described in part 2. Dr. Stanley F. Yolles is the third author, providing a commentary on prevention of mental health problems among older Americans.

To Dr. Donahue and the authors of the papers, the committee extends thanks for their direct assistance and for their willingness to share their long years of concern and experience in this field. The committee also has a debt of gratitude to all helped in the preparation of the project studies in part 2.

It is to be hoped that this report, published at a time when national attention will be centered on a White House Conference on Aging, will assure that a vital, but often neglected, crisis in aging will receive the attention it merits.

FRANK CHURCH, *Chairman,*
Special Committee on Aging.
EDMUND S. MUSKIE, *Chairman,*
Subcommittee on Health of the Elderly.

CONTENTS

Page

Preface ... III

PART ONE

Introduction ... 1
- Group for the Advancement of Psychiatry ... 3
- The American Psychiatric Association ... 4
- The American Psychological Association ... 5
- President's Task Force on Aging ... 5
- White House Conference on Aging Workbook ... 6

Conclusion ... 6
- I. New Trends, But a Chronic Crisis ... 7
  - A. The Numbers: In Institutions and Elsewhere ... 8
  - B. Attitudes. "Dread Engenders Denial" ... 9
  - C. Growing Role of Nursing Homes ... 12
  - D. "Cost-Cutting" by States ... 16
- II. Shortcomings in Medicare and Medicaid ... 19
  - A. Medicare ... 19
  - B. Medicaid ... 20
- III. Shortcomings in Community Mental Health Programs ... 21
- IV. Shortcomings in National Institute of Mental Health ... 23
- V. Shortcomings—Education and Training ... 24

Interim Recommendations ... 25

PART TWO

Action Programs to Prevent, Reduce, or Improve Institutionalization: Introduction ... 29

Project Study One—Ypsilanti State Hospital: Milieu Therapy and Re-entry into the Community ... 33
- One: The State Hospital and the Elderly ... 34
  - The Therapeutic Community ... 34
  - Introduction to the Ward—the treatment program begins ... 35
  - The role of worker ... 35
  - The patient as consumer ... 37
  - The role of friend and group member ... 37
  - The ward population—patient and staff ... 38
  - Discharge and placement planning ... 39
  - Some significant results ... 40
  - Summary: hospital phase ... 41
- Two: The Community—Operation Friendship ... 42
  - The establishment of a social agency for ex-mental patients ... 42
  - An activity program that is varied and meaningful ... 43
  - An attempt to answer a greater need—project older American ... 44
  - Wanted—community awareness and response ... 44
  - Placement results—and some problems ... 45
  - Looking back—some recommendations for the future ... 48

Project Study Two—North Carolina State Hospitals and Satellites:
- A Statewide Mobilization of Resources ... 51
- Background: The beginnings of a State program ... 52
- Organization of services to provide comprehensive care ... 53
- When the "current" State hospital patient becomes a "former" patient ... 54
- Refinements: Specialist services and sharpening community awareness ... 56
- Hospital sponsored workshops ... 56
- Geropsychiatry training project ... 57

	Page
Project Study Two—Continued	
Section of psychological services	58
Title XIX vendor payments	58
Homemaker services	58
Rural areas—the great challenger	59
Results and significance	60
Project Study Three—The San Francisco Geriatric Screening Project: Complexities and Rewards of Prevention	62
Background: Commitment in California	63
The geriatric screening project begins	64
Who comes to the San Francisco geriatric screening project?	66
The screening team in action—innovations	66
After the screening: alternative to commitment	67
The patient who cannot pay	69
Dramatic results from screening	70
Some unresolved problems	72
Implications for future planning—the fruits of prevention	73
Project Study Four—Harlem hospital outpatient geriatric program: Outreach and group therapy in an urban ghetto	75
Background	76
An additional asset—mental health assistants	79
Conclusion—and some thoughts of the future	81
Project Study Five—Swope Ridge Nursing Home: Prevention and rehabilitation	85
The nursing home's role in mental health	87
Swope Ridge—a way of life	87
A physical environment designed to promote social activity	88
Primary phase—physical rehabilitation	88
An opportunity to learn new skills, and re-learn old ones	89
A role in the decision-making process	91
A volunteer program that brings the community into the nursing home	92
Commitment to learn—a well-trained staff	93
A new dimension—outpatient services	94
Future thrusts—a health complex for the elderly	95
A nursing home that wants to "do more" is faced with problems	96
Conclusion	97
Project Study Six—Philadelphia Geriatric Center—Plans for the Comprehensive Approach	99
A "geriatric community" and how it grew	100
The next step—the geriatric day care center	102
The biggest step of all—the Weiss Institute	103
Success brings serious problems to light	105
Conclusion—Institutions versus community based programs—both are needed	107
Some other programs worthy of note:	
State hospital programs	108
General hospital programs	111
Statewide programs	114
Programs in other institutions	114
I. Training programs in process at Drexel Home	116
A. Medicine	116
B. Nursing	116
C. Social work	116
D. Other	117
II. The Meals on Wheels program	117
III. Neighborhood youth program	118
IV. Community activities of Drexel Home	118
A. Block club meeting	118
B. PTA	119
C. Crusade of mercy tours	119
D. Miscellaneous events	119
V. Psychiatric services	119
Community programs	121

PART THREE

Statements on mental health issues related to aging and aged Americans: Page

I. Articles by Robert M. Butler, M.D ... 125

A. The mental health care of older Americans present and future prospects ... 125

B. Psychiatry and age-ism. Proposals for action in the Year of the White House Conference on Aging ... 129

II. The case for multi-system provision of comprehensive health aid for the aged, by Alvin I. Goldfarb, M.D ... 131

The institutionalized elderly ... 133

Institutional populations ... 136

Attitudes toward institutional use ... 139

Mortality ... 139

Attitudes and myths ... 140

Discussion of project studies ... 141

Conclusion ... 144

III. Prevention of mental health problems in the elderly, by Stanley F. Yolles, M.D ... 146

References ... 150

APPENDIXES

Appendix 1. Recent evaluations: Mental health care and the elderly:

Item 1. Introduction and summary of recommendations, excerpted from "Toward a Public Policy on Mental Health Care of the Elderly" ... 152

Summary ... 154

Item 2. Critical issues facing the 1971 White House Conference on Aging ... 156

Item 3. Proposed recommendations ... 163

I. Alleged loss of intellectual functioning ... 163

Recommendations ... 163

II. Education ... 163

Recommendations ... 164

III. Mental health ... 164

Recommendations ... 164

IV. Environments for the elderly ... 164

Recommendations ... 165

V. Institutions for the aged ... 165

Recommendations ... 165

VI. Professional manpower and training ... 165

Recommendations ... 165

VII. Research and demonstration ... 166

Recommendations ... 166

VIII. Government organization ... 166

Recommendations ... 167

Item 4. Excerpt on "Mental Health" from "Toward a Brighter Future for the Elderly" ... 167

Introduction ... 167

Recommendation 13 ... 167

Recommendation 14 ... 168

Appendix 2. Additional Material:

Item 1. The effect of Medicare/Medicaid on mental health services to the elderly ... 169

Medicare:

Supplementary medical insurance; part B ... 169

Medicaid ... 170

Item 2. Programs of the National Institute of Mental Health relevant to the mental health of the aging ... 172

Item 3. Veterans Administration programs for the elderly mentally ill ... 174

Item 4. A review of the impact of the community mental health center movement on psychiatric services to senior citizens ... 177

Summary ... 179

Item 5. Statement by the Hon. Edmund S. Muskie, in support of appropriations for staffing of community mental health centers ... 179

Appendix 3. Glossary of terms ... 183

Appendix 4. Geropsychiatry in the General Hospital, by Alvin I. Goldfarb, M.D ... 186

"Unless concerted and aggressive efforts are made by those who recognize the need of older persons for special advocacy and programming, their neglect will continue under a new guise. The new programs which attempt to restructure broad patterns of mental health care may continue to perpetuate the exclusion of the aged." [1]

PART ONE

INTRODUCTION

Widespread confusion and contradictions in public health policy on mental health care of the elderly are causing heavy economic, social, and psychological costs among older Americans and their offspring.

Some elderly persons pay that cost by remaining in institutions, even though they could—with special services and understanding—return to the community.

Some elderly persons pay that cost by being transferred from one institution (often a State hospital) to another (usually a nursing home) even though the move may be against their best interests.

Some elderly persons pay that cost by remaining in their own homes or apartments in confusion or despair, denied access to services which help others, but not them.

All Americans share in paying the cost in terms of fear (usually unrecognized) that their own later years may be so blighted.

This report by the Senate Special Committee on Aging has been written partially to have an impact upon the White House Conference on Aging, but it is published at this time primarily to help assure that the 1970s will bring the progress in this area that did not take place in the previous decade.

Certainly, hopes for such progress were high at the time of the 1961 White House Conference on Aging. As will be seen later, delegates at that Conference issued far-sighted, humane, and practical suggestions.[2] If adopted, those recommendations would have provided a suitable framework for much-needed change in attitudes and practices related to mental health of the elderly.

Instead, it appears to many critics that the 1960's resulted in retrogression in many important respects.

Consequently, problems related to mental health care of the elderly must be regarded as among the most pressing issues that will be discussed at the White House Conference and in the follow-up meetings intended to result in implementation of Conference recommendations.

---

[1] From "Congregate Care Facilities and the Elderly," by Elaine M. Brody, M.S.S.A., Philadelphia Geriatric Center, in Oct. 1970 "Aging and Human Development."

[2] See preface by Dr. Wilma Donahue to the second part of this report, p. 29.

In addition, the entire nation should be more adequately informed about a chronic crisis which—while it takes new forms—persists and afflicts the lives of those who face mental disorder and old age at the same time.

To this Committee, it is clear that the following facts must be faced:

—State mental hospitals are confronted with a 2-way squeeze. They are ordered by economy-minded State legislatures (and less directly, by the U.S. Congress) to reduce "inappropriate institutionalization" of the elderly and others. But when attempting to "return the patients to the community", they are confronted with shortages, or non-existence, of the very services that would make it possible for patients to make a successful adjustment.

—There is good reason to believe that widespread concern about "dumping" of patients into nursing homes or custodial quarters is justified. Funding cutbacks are being achieved in a number of ways which could and are resulting in direct harm to the elderly. Even "screening" to prevent placement in State mental hospitals is regarded by some simply as a means of denying *any* treatment or provision of services. Imposition of arbitrary age limits—denying entry into a State hospital—appears to have no sound medical justification.

—Unresolved questions related to Medicare and Medicaid are intensifying many problems related to mental health care. Medicare discriminates against provision of mental health services for older Americans. Medicaid fails to live up to a legislative mandate that it provide such service.

—Community mental health care centers, authorized by legislation 8 years ago, are failing to meet the needs of the elderly, and thus are increasing the pressures for institutionalization even when the institutions are less capable of meeting those pressures. On the other hand, wholesale discharge of patients from state hospitals are causing new pressures for local treatment at community mental health care centers: a trend which adds to the strains already placed upon those facilities in serving other age groups.

—Several pilot programs to reduce institutionalization have achieved some success, but thus far these "islands of progress"[3] have not been absorbed into a coherent system with concrete objectives. Their limited achievements have thrown into sharp relief the appalling inadequacies elsewhere.

—Mental health needs of the elderly are given a low priority, even by practitioners, who thus ignore a growing body of evidence that reversibility of many aliments (though most certainly not all) is possible. They are also ignoring the very real prospect that older persons are going to be less and less willing to accept discriminatory practices based largely on what one psychiatrist calls "age-ism", or negative and even hostile attitudes toward persons who happen to be old.

---

[3] As described by Dr. Donahue in preface cited in footnote 2.

—Court decisions [4] in 1966 and in 1971 have declared that there is a legal right to appropriate community facilities for persons inappropriately placed in institutions. These decisions point the way to more satisfactory attitudes and practices than now exist. But, though guaranteed by the courts, the alternatives do not exist, or exist in short supply—with the elderly at the bottom of the priority list for treatment.

—Although the National Institute of Mental Health was presented with a budget which was higher than last year's appropriation, the Congress considered the budget estimate to be insufficient, particularly in view of the intensifying problems directly related to mental health care.

—According to the American Psychological Association,[5] "at least 3 million older persons require mental health services, but of this number "a bare 20 percent have their needs met through existing psychiatric facilities." (Even this 20 percent estimate may be optimistically high, according to Dr. Carl Eisdorfer, APA Task Force Cochairman.)

In short, public policy in mental health care of the elderly is confused, riddled with contradictions and shortsighted limitations, and in need of intensive scrutiny geared to immediate and long-term action.

This conclusion is based partially upon testimony and other information received by this Committee. It is also suggested by five recent policy statements made by responsible and well-informed study groups.

Group for the Advancement of Psychiatry [6]

The GAP report,[7] issued in November 1970, said that the effort to solve long-standing problems of chronic hospitalization has now resulted in a swing of the pendulum to "rapid and premature discharge from the mental hospital." In describing recent confusion of the Medicare and Medicaid programs the report said: "the trend toward 'moving bodies' from State hospitals to extended care facilities in order to attract larger Federal payments increases the alarming prevalence of relocation and its accompanying disorders." GAP quoted studies indicating a rise in mortality rates following relocation of several elderly populations.

GAP sees the psychiatric hospital as "an integral and necessary component of the therapeutic continuum for elderly psychiatric

---

[4] Chief Judge David L. Bazelon of the U.S. Court of Appeals upheld the legal right to alternative community facilities in *Lake* v. *Cameron*, 1966. That case dealt with a patient, commited to St. Elizabeths Hospital in Washington, D.C., but found later not to require institutional care. On March 12, 1971, Judge Frank M. Johnson of Federal District Court ruled in Montgomery, Alabama, that patients involuntarily committed to institutions through civil procedures have a constitutional right to "adequate treatment from a medical standpoint." The Judge said that approximately 1,500 of the patients at Bryce Hospital in Tuscaloosa are elderly persons who were receiving only "custodial care without psychiatric treatment." The State of Alabama was given 6 months to submit evidence it has established appropriate treatment programs. In his report of September 23 to the Court, the State Commissioner of Mental Health admitted to numerous shortcomings—including continued detainment of 1,800 "inappropriate patients" at Bryce. The Commissioner also pointed out that his Department had requested a budget of $100 million for the next 2 fiscal years, approximately a 100 percent increase over the previous biennium budget. The Legislature has not yet acted on the budget, and the Commissioner requested the right to file a supplemental report with the court within 30 days after a budget is approved by the Alabama legislature.

[5] See Appendix 1, item 3 for proposed recommendations.

[6] The Group for the Advancement of Psychiatry has an active membership of approximately 200 psychiatrists who are organized in the form of a number of working committees. At the time of its report, Dr. Jack Weinberg of Chicago was Chairman of the GAP Committee on Aging. He was succeeded in 1971 by Dr. Robert N. Butler, Washington, D.C. Other members are: Alvin Goldfarb, New York; Lawrence F. Greenleigh, Los Angeles; Maurice E. Linden, Philadelphia; Prescott W. Thompson, San Jose, California; and Montague Ullman, Brooklyn.

[7] "Toward a Public Policy on Mental Health Care of the Elderly," Report No. 79 GAP, 419 Park Avenue South, New York, New York, 10016.

patients." But it also called for development of comprehensive diagnostic and treatment centers, at each point along the sequence of neighborhood health centers, community mental health centers, and hospitals.

"Irreversibility," GAP declared, "must never be casually (and stereotypically) assumed. Many mental disorders affecting the aged are subject to amelioration. Acute brain syndromes intervene in the course of chronic brain syndromes and are reversible. Depressive, paranoid, and behavioral reactions may be components in the clinical course of patients with organic brain damage and can be controlled. Depression may be masked an as organic state and, if recognized, can be treated."

GAP also emphatically makes the point that there are two groups of older patients in our mental hospitals: (1) those who developed their mental illnesses as a result of old age and its attendant traumata; and (2) those who developed mental illnesses early in life and who grew old in the hospital.

There is no single "type" of elderly patient; they have all the needs for psychiatric care that younger persons do, but their needs are complicated by the fact of age and by the many disabilities that accompany age.

GAP made a large number of recommendations which are discussed elsewhere and which are summarized in appendix one.

The American Psychiatric Association

An APA Task Force, established to report on critical issues facing the 1971 White House Conference on Aging, described progress made during the last 2 decades as "infinitesimal." Among the reasons for this slow pace: the growth of the aging population, the recognition that their diversified needs may require diversified—and expensive—services; and perhaps most fundamentally, are problems related to attitudes.

As the APA Task Force put it: "Prejudiced and stereotyped thinking has resulted in faulty conclusions that treatment programs for the elderly are doomed to fail. Evaluating prognosis, and especially evaluating the effectiveness of treatment, should be dependent on the implementation of a plan which has taken into account the findings of a thorough diagnostic appraisal. When a comprehensive treatment program has been instituted, the results are often quite surprising. At the same time, one must recognize that in dealing with elderly persons, the usual criteria for improvement do not always apply. Depending on the status of the individual and the impairments being treated, the therapeutic objective may be maintenance of functional capacity at the current level. . . . Restoration to a functional capacity considered ideal for a young person should not be in the conceptual framework, or at least not the only one, for evaluating effectiveness of care of aged persons."

Warning developers of new programs that they should not be seduced by "sloganeering," the APA said: "An arbitrary administration decision to exclude elderly pateints from admission to state hospitals is a case in point. Certainly some elderly persons *will* become chronic residents, *but who can determine the outcome of treatment before it is instituted?"*

It may seem self-evident that adequate diagnosis is the keystone for determining a program of care which could lead to reversal of a

chronic condition. And yet, what has been called "therapeutic nihilism" leads quite often to cursory examination culminating in (1) denial that the old person has a mental disease and that he is simply behaving peculiarly because he is old, or that (2) the old person is untreatable because "senility" is irreversible.

The APA Task Force warns that no single "system" of care will be applicable to all the aged:

> They comprise a heterogeneous group; and programs have to be devised that take into account ethnic differences, impairments, facilities available locally, techniques for ongoing care, a program to meet a variety of needs, and a program adaptable to changes in health and social status is needed. High standards of care and expectations should be outlined for all practitioners whether they be in the public, nonprofit, or proprietary sectors. Supervision, probably by state and federal authorities, as well as peer review techniques, must be continued and yet techniques must be used which assure adequacy of care without stifling the practitioner with unreasonable restrictions.

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

Still another task force was established by this association, representing approximately 30,000 psychologists. At a 3-day conference in June 1971, the Task Force agreed to present recommendations [8] to the director of the White House Conference on Aging for with the request that "they be transmitted to those persons at every level of government charged with the creation and implementation of public policy as it affects all Americans." To overcome "a great unmet need for mental health services for the aged," this Task Force recommended:

> That federal agencies such as the National Institute of Mental Health pay much more explicit attention to the mental health problems of the elderly, whether in community agencies, comprehensive mental health centers, mental hospitals, or institutions for long-term care. Studies on the prevention and treatment of mental illness need to be accelerated. Alternatives to institutional care must be developed and evaluated for their effectiveness.
>
> An intensive research effort is needed to acquire more precise data on the effectiveness of existing services and additional services required to meet the need. In addition, more basic knowledge is required on the causes of specific mental disorders so that primary preventive techniques may be developed to reduce the incidence of mental disorders and their associated disabilities.

PRESIDENT'S TASK FORCE ON AGING

Its report [9] regarded limitation [10] under Medicare for the treatment of emotional problems as an archaic throwback. The report declared:

---

[8] Proposed Task Force Recommendations were issued on September 1, 1971 by the American Psychological Association, 1200 17th Street, N.W., Washington, D.C. 20036. Complete text appears in appendix one.

[9] "Toward a Brighter Future for the Elderly," The Report of the President's Task Force on the Aging," April 1970. Its discussion of mental health and the elderly appears in appendix 1, p. 167

[10] See p. 19 for additional criticism of Medicare policy.

"Because the Task Force sees the resolution of these problems as an integral part of the total health needs of the elderly, it advocates that every possible effort should be made to encourage the use by older persons of available mental health services. To that end it urges that Medicare coverage for the prevention and treatment of emotional difficulties should be reviewed and liberalized. The Task Force further believes that "the range of *problems associated with the provision of mental health for the elderly constitutes a major public policy issue which requires positive and innovative Federal direction.*" (emphasis added)

Concern was expressed about the following problems:

1. The use of State mental hospitals as custodial facilities for large numbers of chronically ill or disabled older persons who are not in need of active psychiatric care because alternative living arrangements with psychiatric consultation or support do not exist;
2. The absence within many State mental hospitals of psychiatric services for those elderly patients who do require such care;
3. Indiscriminate regulation against the admission of older patients to public psychiatric facilities;
4. Recent trends toward release of elderly patients from State institutions primarily because they are old in the face of the absence of community services to support these released patients; manpower shortages;
5. And the link between adverse social conditions and the incidence of mental illness among the elderly.

WHITE HOUSE CONFERENCE ON AGING WORKBOOK.[11]

This publication, based in part on a technical paper prepared for the conference, said that "mental health needs of the elderly have been long neglected by society." It gave this summary of present inadequacies in services: "The major problems existing in present services for the elderly mentally ill are related to discontinuity and fragmentation of care, with respect to both the private and public sectors. There is too often overlapping of responsibility and authority, duplication of services, and shifting of patients from one agency to another. Inadequacies in facilities and services of all kinds arise from too few facilities, manpower shortages, lack of adequate financing, lack of training programs for caretaking personnel and of educational programs for the public, and program deficiencies that result from lack of knowledge about the best programs to support, and from lack of personnel to offer programs. *It would be hard to point to an area in the field of care for the mentally ill aged where services could be judged adequate.*" (emphasis added)

CONCLUSION

To the Senate Special Committee on Aging, the mental health problems of older persons cannot be understood solely in terms of the numbers affected (they are relatively small), nor in the heavy expenditures required to deal, even inadequately, with their needs. The paramount issue is what the GAP report describes as "the

---

[11] "Work Book on Health," for participants in Community White House Conferences on Aging, Section on Health, January 1971; by White House Conference on Aging, Washington, D.C. 20201.

continuing accumulation of untreated illnesses and disabilities" in our society.

On the eve of a White House Conference on Aging—and at the early beginnings of intensifying debate on proposals for a national health insurance system—it may be unpleasant to admit that an "accumulation of untreated illnesses" is causing heavy burdens for those elderly Americans now in need of appropriate mental health services and the many more who can expect to suffer from such needs in the future unless the problem is understood and satisfactorily dealt with.

What emerges, even in a preliminary survey of this nature, is mounting reason to believe that the very multitude of conflicting concepts—translated into "programs" of one kind or another—are being imposed, quite often, without adequate, objective information about the impact of those changes upon the elderly person in need of medical care.

What may be called a satisfactory "return to the community" may simply mean that the patient is no longer heard from. What passes for "preventive screening" could really be a denial of any care at all. What may be hailed as new resources for treatment in the community may often be age-restricted.

Clearly, positive results can and do result from the programs just described. The second part of this report is devoted to accounts of several promising projects, including an Ypsilanti, Michigan, program which has resulted—in a significant number of cases—in a genuine readjustment to community life.

But it is equally clear that, when more wholesale steps are taken, we do not really know all we should know about the impact of such experimentation upon the people most affected: the patients called upon to adapt to new treatments or new surroundings.

This paper is the beginning of a new effort by the Senate Special Committee on Aging to focus attention on that problem at the White House Conference and beyond. It should be regarded as an interim report, which in its first section provides a brief survey of the present situation.

Even though much attention is given to promising experiments, it is recognized in this report that these programs serve only a small proportion of those in need of help. To make use of the lessons already learned on a scale large enough to overcome one of the most serious health problems facing older Americans, a major new unified effort is called for.

I. NEW TRENDS, BUT A CHRONIC CRISIS

Ten years ago, a knowledgeable public administrator wrote a report, "Mental Illness Among Older Americans," for the Senate Committee on Aging.[12]

One of his most bitter complaints dealt with "confusion in the array of services." He wrote:

"A recitation of statistics concerning the aged in mental hospitals is only indicative of the broader problem which exists with reference to the aged and mental illness. The plight of the mental hospitals reflects, frequently, the lack of resources in the community for proper

---

[12] By Elias S. Cohen, then Commissioner of the Office of Aging, Pennsylvania Department of Public Welfare. September 8, 1961.

placement in the first instances, the lack of resources in the community for maintaining the patient upon discharge, and, in many instances, confusion about what the patient needs or what can best serve his particular problems."

His comments unfortunately are still largely true in 1971, as can be seen by another "recitation of statistics," in this report and discussion of trends and counter-trends which have occurred during the last decade.

A. The Numbers: In Institutions and Elsewhere

As has already been indicated, the patient population in institutions falls into two general groups: those who were old when admitted, and those who grew old in the institution. In addition, the elderly patients also have these general characteristics: [13]

1. About 62 per cent of the institutionalized are women.
2. Non-whites constitute 12 per cent of the total population but less than 8 per cent of those over 65 and about 4 per cent of the institutionalized elderly.
3. Chances of becoming a resident of an institution increase with advancing age. Only 2 per cent of those between 65 and 74, but more than 10 per cent of those over 80, reside in institutions. In contrast to a median age of 73 for the total over-65 population, about half of the institutionalized are over 80.
4. Poor economic status increases the probability of institutionalization. Twice as many public assistance recipients than non-recipients are institutionalized.

Much discussion of mental health needs of the elderly centers upon the population of 65+ patients in state hospitals. Undoubtedly that number is significant, but cannot be regarded as the sole criterion of whatever progress is being made.

In State Hospitals: Geriatric patients now occupy about one out of every five beds in mental hospitals in the country.

Approximately 23 percent of first mental hospital admissions are accounted for by persons over 55 years of age.

As of 1969, about 111,000 persons aged 65 and over were in State mental hospitals.

This was a decline of approximately 47,000 since 1955, a decline caused by several factors: (1) intensive efforts in several States to return patients to the community (2) a deliberate policy in several States to refuse admittance to persons above a given age and (3) some increase in outpatient services because of Medicare and Medicaid and because of the establishment of Community Mental Health Centers.

In Nursing Homes and Long-Term Homes for Aged: Nursing homes received many of the patients who were removed from State mental hospitals during the past decade, and they also received many other persons with mental impairment during that same period.

An estimated 55 percent of the residents in nursing homes and related facilities serving the chronically ill are mentally impaired persons.

---

[13] Summarized from data assembled by Elaine Brody, M.S.S.A., in paper cited in footnote 1.

According to the latest available information from the National Center for Health Statistics a *minimum count* of persons with mental impairment in such institutions is 186,000, with the likelihood that this is a very conservative estimate.

"In the Community" Studies have indicated that anywhere 15 to 25 percent of elderly persons living in their own residences have some degree of mental impairment.

It should be remembered that "having a degree of mental impairment" does not necessarily mean that institutionalization or even elaborate outpatient service is required. As will be seen in the second half of this report, some forms of impairment can be delt with in practical, relatively inexpensive ways, if services have been rationally organized and if they are available. But it must also be admitted that such a state of affairs is still more the exception than the rule.

B. Attitudes: "Dread Engenders Denial"

As has already been suggested, negative attitudes toward the elderly play a significant role in balking progress. To Robert Butler, Chairman of the Committee on Aging for the Group for the Advancement of Psychiatry, it is clear that "dread engenders denial": the idea of growing old, when combined with fear of helplessness caused by mental illness, causes the general public—and practitioners, too—to turn their backs upon the problem and upon the people affected by that problem.

And yet, GAP and others have found reason for encouragement about "reversibility" of many mental illnesses, even though they are careful to point out that many patients in State mental hospitals have combinations of physical and mental ailments which require the kind of care that only institutionalization can provide. Nevertheless, the prospect of progress is real, even though apparently our attitudes may not yet be significantly altered by that prospect.

Dr. E. W. Busse, former Chairman of the Duke University Center for the Study of Aging, gave this estimate of the situation: [14]

> The advancing edge of knowledge that will eventually cut through the thick wall of pathology accounting for the many psychiatric problems of the aged is moving ahead slowly, but surely. Knowledge is increasing regarding the biological aspect of brain function and its relationship to diseases of the body. Of equal importance is the increasing recognition of multiple causes of phychiatric disorders in the elderly: socioeconomic factors, environment, nutritional variations, and the physiological changes of aging.

A similar evaluation—and a complaint about present attitudes—recently made by Dr. George James, Dean of the Mount Sinai School of Medicine in New York City.[15]

> Our standards should change, for there is certainly an increasing body of evidence that much mental illness in older people is not essentially organic, much of it can be reversed, and much of it could be prevented . . . What should be an

[14] Article, "Geriatric Psychiatry," in "Medical World News,"—Psychiatry—69.
[15] In article, "Mental Health Services for Older People," GERIATRICS Magazine, May, 1967.

69-261 O - 71 - 2

exciting challenge to medicine is almost ignored. The disoriented oldster, for whom much could be done, is shipped off to a State mental hospital or nursing home. Not much effort is given to doing anything really constructive for him, despite evidence that there is reason for hope. We will not solve the problem of mental illness in older people unless we can first convince ourselves that something can be done about it.

Dr. Robert W. Gibson, Medical Director at the Enoch Pratt Hospital in Towson, Maryland, recently chided the "therapeutic pessimism," or reluctance among psychiatrists to undertake treatment of older adults. He gave this evidence to support his position that "psychiatric illness in the older patient is worth treating:" [16]

1. A review of records of 138 patients over 65 years of age admitted to a private hospital over 3 years indicated that 80 percent of the cases initially received a poor prognosis. But some 60 percent of these patients were discharged to their homes in 90 days or less.
2. Another study showed that 54 percent of 138 65+ patients were able to return to their homes after a median length of stay of 42 days.
3. A survey of 49 private psychiatric hospitals showed that 75 percent of 6,400 65+ patients improved sufficiently to return to their homes within two months.

Gibson also points out that depression is prominent in the psychiatric difficulties that occur in many older patients. To practitioners who have a pessimistic outlook about treatability of the elderly, depression may often be confused with more serious conditions. But, as Gibson points out, depression often responds quite dramatically to psychiatric treatment."

Additional evidence about the positive results that can result from sensitive and highly motivated treatment was given to a Senate Subcommittee [17] recently by Dr. Karl Menninger, founder and chairman of the board for the Menninger Foundation.

He told about 88 aged patients classified as hopelessly "senile" and psychotic in a geriatric ward of the Topeka State Hospital. Many had been there for more than 10 years; one had been there for 58 years.

Dr. Menninger assigned a young doctor to the ward, along with "a therapeutic team of cheerful young nurses, aides, social workers, and psychiatric residents." With this team, "Each patient became a focus of attention. The ward was transformed from being a museum of dying human specimens into a hospital home in the best sense."

The new program included music, television, canaries as pets, new lighting fixtures, birthday parties, and other activities and physical improvements.

Dr. Menninger reported these results:

> By the end of the year, only nine of these 88 patients were still bedfast. Only six of them were still incontinent. Five had died. Twelve had gone on to live with their families. Six had

---

[16] In "Medicare and the Psychiatric Patient," in Psychiatric Opinion, June 1970.

[17] In testimony before the Subcommittee on Long-Term Care, Senate Special Committee on Aging, at hearing on "Trends in Long-Term Care," Chicago, Illinois, Sept. 14, 1971.

gone to live by themselves, and four had found comfortable nursing home provisions outside the hospital. Four of the original 88 were now gainfully employed and self-supporting.

Dr. Menninger attributed much of the improvement to "the spirit of the place." He explained:

> There actually is a spirit in that place which says you want that person . . . You must give some kind of special attention to each person.

Is "Senility" Treatable? Dr. Menninger and others are critical of the way in which "senility" is used by caregivers and others. One psychiatrist has pointed out that even the dictionary definition equates "senility" with old age [18]. In practical everyday terms, confusion over the term can lead to unfortunate consequences for the elderly. An admitting physician may regard an older person as "merely senile" and therefore not in need of any treatment: his ailment is just something that comes from "growing old." If admitted, the patient may suffer from another problem: because he is "senile" he may receive only minimal care or none at all. Many practitioners believe that "chronic brain syndrome" is a much more reliable term in making diagnosis. (See Glossary of terms, Appendix 3). When we consider the fact in 1966 Chronic brain syndrome was one of the most frequently diagnosed mental illnesses, we can see the importance, once again, of precise diagnosis.

What appears to be "senility," moreover, may often be a temporary physical or emotional condition caused by problems which may intensify in the later years of life: malnutrition caused by poor eating habits or poverty; overuse of certain pain-relieving or tranquilizing drugs, some forms of kidney trouble, circulatory impairments which reduce flow of blood to the brain, traumatic events, adverse environmental conditions, and the actual destruction of nerve tissue. Physiological or functional conditions of the kind listed above are, in many cases, treatable. Social or emotional causes of disorder may pass of their own accord or be made to pass by direct intervention.

Dr. Charles H. Kramer, President of the Kramer Foundation and Clinical Director of the Plum Grove Nursing Home, regards the word "senility" as a "wastebasket term which is used to describe a clinical syndrome in an older person" which has to do "with things like childishness, regressive behavior of various kinds, forgetfulness, lack of contact with reality, confusion, these kinds of mental reaction." [19]

He also gave this comparison:

> If an older person does not know where he is, and he misidentifies people, and he does not use good judgment, and his intelligence is not functioning as well as it used to be, we speak of him as being senile, *but if that same person were 30 instead of 70, we would speak of him as being psychotic.* (emphasis added)

Again, as in Dr. Menninger's example, Dr. Kramer saw the possi-

---

[18] Victor M. Kassel, Salt Lake City geriatrician and former Chief of a Geriatric Section at a Veterans Administration Hospital, wrote in the November 1965 issue of the Rocky mountain MEDICal Journal, that Websters Third New International Dictionary defines "senile" as "of, relating to, characteristic of old age."

[19] In testimony at hearing cited in footnote 17.

bility of "remarkable change" in the behavior of an older person as the environment around him changes:

> Those people who approach him in a way . . . of antagonism will frequently see a senile person rather than someone who approaches him as a human being, who still has some assets and some brain function.

Impressive as many recoveries have been, however, Dr. Alvin Goldfarb[20] and others have repeatedly taken note of the fact that many patients in mental hospitals and other long-term-care institutions suffer from a variety of illnesses, physical as well as mental. Mortality soon after admission is high, possibly because of the generally poor physical condition of so many of the patients at the time they enter the institution. To Elizabeth Markson of the New York State Mental Health Research Unit, a study of one mental hospital in that state provided evidence that the institution was a "Geriatric House of Death," where low-income, very ill persons were sent to die largely because there was no place else for them to go, even though they may not have suffered primarily from a mental disability.[21]

C. Growing Role of Nursing Homes

Typically, concern about mental health needs of the elderly centers around the patient who is inappropriately committed to a State mental hospital, or detained in such an institution long after the need for such treatment is over.

There is good reason for concern on both points. Recently, for example, a National Institute of Mental Health Survey indicated that more than two-thirds of the patients at St. Elizabeths Hospital in Washington, D.C. were well enough to be transferred to other care facilities including nursing homes, foster homes, halfway house facilities, and the patients' own homes.[22] Authors of the report indicated that their findings are apparently similar to conditions in most public mental hospitals throughout the Nation.

At the same time, hospital officials and others said that "mental hospital warehousing" exists primarily because satisfactory alternatives are in short supply. The "return to the community" quite often is impossible simply because there is no place else to go.

Within recent years, however, the nursing home has served with increasing frequency as a place to which State mental hospital patients are transferred. As has already been noted, nursing homes now probably have more cases of mental impairment than State hospitals. This trend has caused considerable concern. As the GAP report sees the situation:

> In an effort to solve the long-standing problems of chronic hospitalization, the pendulum has now swung in the direction of rapid and premature discharge from the mental hospital. Frequently, a patient is discharged before his treatment is completed . . . . Furthermore, in the recent confusion of the Medicare and Medicaid programs, the trend toward "moving bodies" from State hospitals to extended care facilities in

---

[20] For additional commentary by Dr. Goldfarb, see his essay in part 3 of this report.

[21] See "The Geriatric House of Death: Hiding the Dying Elder in a Mental Hospital," in Aging and Human Development, February 1970.

[22] As reported in the Washington Post, August 11, 1971.

> order to attract larger Federal payments increases the alarming prevalence of relocation and its accompanying disorders. A study by Margaret Blenkner showed that, even with careful preparation of the older person before his being moved, mortality increased in the relocated population. Other studies show similar findings.
>
> In addition, the present trend toward moving aged patients from mental hospitals into the community leads all too often to their placement in nursing homes that provide no psychiatric care at all.[23]

One dramatic example of the consequences widespread transfers from State hospital to nursing homes occurred this year in Illinois, where critics alleged that the process of "moving bodies" had contributed to the deterioration of an already strained nursing home network.

Chicago: Impact on Nursing Homes: In September 1969, an Illinois State law began the "Accelerated Discharge Program of Elderly Patients from Illinois State Mental Hospitals." The intention was to remove a large number of older patients, perhaps as many as 7,000 by mid-1970 in order to reduce costs to the State[24] and to provide alternatives said to be superior to the State hospital.

Despite assurances from State officials that released patients would have suitable "aftercare" to help in their return to the community, Chicago officials were critical of the transfer program on several counts.[25] They said that:

1. Far in excess of 50 percent of discharged patients were sent to nursing and residential care homes in Chicago.
2. Some are being sent into rooming houses and converted "low-class" hotels.
3. Nursing homes in Chicago were already crowded.
4. Many of the transferees had literally grown old in the State hospitals, and were unable to adjust to life outside the institution without sensitive, comprehensive "aftercare".

Early in 1971, the Chicago Tribune and the Better Government Association of Chicago joined forces for a survey of nursing home conditions in that city. They concluded[26] that patients in several "warehouses for the dying" were receiving poor treatment, that several owners were receiving excessive profits, and that shocking conditions existed because of lax inspection. The Tribune articles asserted that the state transfer program had undoubtedly contributed to the problem. To the City Health Commissioner, Dr. Murray C. Brown, there was a clear relationship between the state program and the nursing home problem:

> We believe that the deterioration of facilities and care in Chicago nursing homes is directly related to the aforemen-

---

[23] For details on a program intended to avoid such pitfalls in "return to the community, see Project I in Part II of this report.

[24] Dr. Albert Glass, Director Illinois Department of Public Health testified before the Subcommittee on Long-Term Care on April 3, 1971 that the average payment by the State of Illinois for a mental patient discharged to a nursing home was $300 per month while the cost to the State for this patient in State Mental hospitals was about $550. See: Trends in Long-Term Care, Part 13, p. 1305.

[25] See testimony by Mr. Robert Ahrens, Director of the Division of Senior Citizens, Chicago; and Dr. Murray C. Brown, Chicago Commissioner of Health, Hearing on "Trends in Long-Term Care", by the Subcommittee on Long-Term Care, Senate Special Committee on Aging, Chicago, Illinois, April 2-3, 1971.

[26] Major articles from the Chicago Tribune series appear on pp. 1137-1185 of transcript cited in footnote 25.

tioned policy changes made in 1969 by the Illinois State Legislature, the Governor, and the State Department of Mental Health.[27]

Dr. Brown also submitted a letter describing north side Chicago as a "psychiatric ghetto" in which between 12,000 and 15,000 mental patients now reside in nursing homes and unlicensed halfway houses.

In defense of the state policy, state officials have told the Senate Committee on Aging that:[28]

1. Careful standards of selection, preparation, placement, and follow-up are followed.
2. Readmissions to mental hospitals from the elderly placement group is less than 10 percent.
3. Elderly patients placed through the Geriatric Transfer Program represent a small portion of the nursing home occupancy, not exceeding 5 or 6 percent.

Misgivings about the State program, however, seem to be deep-rooted. Dr. Jack Weinberg, Clinical Director of the Illinois State Psychiatric Institute, and former Chairman of the GAP Committee on Aging, has criticized "the notion, the idea of transferring inordinately large numbers of people into nursing homes from mental hospitals." [29] He also said that he had been overruled when he had suggested in 1969 that a committee of known, proven gerontologists be established to determine, on a case-by-case basis, who was to be transferred out of the hospitals, "in consonance with the person's needs." Dr. Weinberg also related an incident suggesting that the transfer program held the hope of high profits for at least one nursing home owner:

> May I reveal something personally, that when I was asked to supervise this program (he later quit the position) and it was announced, someone in my family was approached by a nursing home operator, asking my brother, to be exact, to approach me to direct patients into his home *and that he would offer me a stipend of $100 per head.* This actually happened and appalled both my family and me. (emphasis added)

Another indication of concern about the transfer program was the action taken by Illinois Association for Mental Health on March 10, 1971. In a press release issued on that date,[30] the Association urged the Governor of Illinois to declare a moratorium on the program "until recent exposures of substandard, inhumane conditions can be explored and rectified."

OTHER CONSIDERATIONS

Large, Statewide transfer programs may provide the most dramatic causes for controversy about "dumping" and related problems. But, even when such transfers occur on a lesser and a largely unnoticed scale, disturbing issues emerge.

The following excerpts from a recent address [31] by Leonard E.

---

[27] p. 1108, transcript cited in footnote 25.

[28] See testimony by Dr. Albert Glass, Director of the Illinois Department of Public Health; and Dr. Albert Snoke, Coordinator of Health Services and Director of Comprehensive State Health Planning Program, in transcript cited in footnote 25.

[29] p. 1213, hearing cited in footnote 25.

[30] See p. 1193 of transcript cited in footnote 25 for text.

[31] Presented at a Seminar, "The Future of the Aging and Aged," sponsored by Duke University and the Southern Newspaper Publishers Association Foundation, June 21, 25, 1971, Duke University, Durham, North Carolina.

Gottesman, then Associate Professor of Psychology at the University of Michigan, provide a helpful summary of such issues:

> . . . today, many elderly patients who might benefit from home supports and many who might not are being treated in nursing homes. With the availability of Federal monies to pay for institutional care. nursing homes are attracting some older people who might otherwise be cared for at home and even some homes for the aged are revising their programs to become eligible for the public dollar.
>
> * * * * *
>
> While mental hospitals are reorganizing into smaller units, nursing homes are becoming *larger*. In Michigan, between 1950–54 only 20 percent of new licensed homes had over 100 beds; in 1965–69, 46 percent were large homes. While mental hospitals were decreasing centralized control, nursing homes have been moving toward *increased control* by a few corporations. In the Detroit area, six corporations control 18 percent of 168 homes and 30 percent of the beds. While mental hospitals have been trying to have more contacts with the non-institutional community, nursing homes are becoming more *cut off*. Current legislation forces nursing homes to create distinctly separated parts with narrowly defined patient populations and rigid staffing patterns. Homes must be either skilled, intermediate or basic care specialists or they cannot qualify for the Federal monies which support 87 percent of nursing home care. For example, a nursing home could not get paid if it shared the care of a patient with a family in a program which exchanged the patient between the home and the nursing home every three weeks or so. Yet, such a program is being highly successful in England.
>
> * * * * *
>
> Mental hospitals have not been successful in offering curative programs to their patients, but some have begun to provide milieus which maximize a resident's opportunity for independence. On the other hand, nursing homes are paid more if their patient is more sick. If a patient were to make her own bed, the home would either have to send her away (recall that nursing home patients generally are there partly because they have no home) or lose payment for her.
>
> Nursing homes are also caught in struggles among public, private and voluntary services. Perhaps because they were caring for persons who were even less socially desirable than mental patients, most nursing homes developed as small marginal private enterprises rather than as either government or voluntary agencies. In the 1950's Medicare legislation and other favorable governmental policies fostered a fast growth of an industry controlled by persons expert in the *construction of facilities* and the management of business. Today these persons, who were never experienced in providing for people's

psychosocial/medical needs have a problem which government did not want and voluntary organizations could not afford. Because of their past financial success, because of a long-standing distrust that government and the voluntary sectors have for business, and because of an implicit social value that "people-care" does not belong in the private sector, there is an atmosphere of great friction between the government, which pays most of the bills, and the suppliers of a service which no one is able to define.

D. "Cost-Cutting" by States

The Illinois accelerated discharge program was only one of several actions taken by state governments to cut costs while at the same time reducing institutionalization. Older patients, because of their large numbers in state hospitals, are directly affected by any such moves. This is particularly the case in actions taken recently in New York State and in California:

Denial of Admission in New York: Faced by pressure to reduce patient population in State Mental Hospitals, the New York Department of Mental Hygiene issued a memorandum in June 1968 which ordered that only patients clearly amenable to psychiatric care and treatment should be admitted to State Mental Hospitals. In the view of the department, "most abuse of this principle occurs . . . in the admission of older applicants." Therefore, their applications would be closely scrutinized.

This decision—according to the Community Service Society of New York—precipitated a crises "which exposed to public attention long neglect on the part of the community in providing adequate care for the ever-growing number of dependent aged." [32]

Geriatric admissions to the mental hospitals were reduced in the first three months of 1969 by 42 per cent, compared to the first three months of 1968, down from 2,001 to 1,152.

"Despite the substantial number of persons involved," said the Society, "no one knows who the aged are who have been turned away, or where they are. Have they died? If not, how are they living? Has their distress been alleviated and if so, in what setting, and by whom have they been helped? What strains have been placed upon their families, and what is the effect on family relationships?"

To explore such issues, A City Task Force To Plan Alternatives to State Hospital Admissions of Aging was formed under the joint leadership of the New York City Office for the Aging and the Citizens' Committee on Aging of the Community Council of Greater New York.

That Task Force, in a report [33] issued recently, provided an excellent summary of the pitfalls that arise when sweeping mandates on health facilities usage are ordered. *But perhaps even more significantly the Task Force recommendations provided a challenging appraisal of*

---

[32] P. 1, "The Elderly and the State Mental Hospital in New York State, A Report of the Committees on Aging and on Health, Department of Public Affairs, Community Service Society of New York, September 1969.

[33] "Report of Task Force to Plan Alternatives to State Hospital Admissions on Aging," July 1971.

the far-reaching actions that must be taken to build a new, and more workable, system.

At the very outset, the Task Force agreed with the State Department of Mental Hygiene that mental hospitals, as they are currently designed and staffed, have been misused as an expedient solution to provide custodial care for certain elderly patients.[34]

"However," the report said, "the Task Force also concluded that State Mental Hospitals should be redesigned to continue to serve at least a portion of the confused, mentally impaired elderly requiring long-term custodial care."

One reason for Task Force concern is the estimate *that each year more than 2,000 elderly patients in New York City, who formerly were served in State Mental Hospitals, will require custodial care which does not now exist.*

The report added: "The Task Force believes that these patients are a State responsibility and calls on the Departments of Health, Mental Hygiene and Social Services to work together to create new and appropriate facilities for this population."

Asking the State Department of Mental Hygiene to assume major responsibility "for planning and financing of those patients and potential patients adversely affected by the 1968 memorandum," the Task Force made these recommendations:

1. Experimental geriatric evaluation projects should be broad-ended to provide proper evaluation for out-patient and in-patient services at medical facilities.
2. Neighborhood-based geriatric centers should be funded to meet problems in each community mental health catchment area.
3. Infirmary sections of homes for the aging which do not now admit residents who are mentally or physically ill (except as internal transfers) should revise their policies to accept, care for, and retain this kind of applicant from the general community.
4. A coordinated program of all-inclusive medical care and psychiatric management and social service should be made available at nursing homes and similar facilities.
5. Vacated sections of existing state mental hospitals should be redesigned to provide other kinds of care.
6. Training programs should be established for the personnel involved in the total care of those older patients who present mental health problems in the institutions in which they reside.
7. Supportive health and social services should be provided to maintain home care wherever possible.

In New York City, where 135,000 persons are on the waiting list for low-income shelter, housing problems are directly related to mental health issues. The Senate Committee on Aging has received testimony indicating that all residents in an entire ward at a State hospital in the Bronx remain in that institution simply because there are no suitable quarters for them.[35]

The Task Force calls for a major effort to develop "special housing for older people to meet their physical, social, psychological, and economic needs."

---

[34] This situation is not limited to urban areas. In testimony before the Senate Committee on Aging (Older Americans in Rural Areas, West Virginia, 1970, p. 757.) State officials said recent studies showed at least 33 percent of all geriatric patients in State mental institutions would be able to live in the community in foster or family care homes if such facilities were available. "Mental hospitals," said one witness, "have accepted society's casualties."

[35] From Dr. Israel Zwerling, Director, Bronx State Hospital, p. 583, "Costs and Delivery of Health Services to Older Americans," N.Y.C., Oct. 19, 1967.

California: Cutbacks and Confusion.—One of the most ambitious programs begun under title XIX, or Medicaid, was California's "Medi-Cal" program of 1966.

Higher costs or other problems, however, have resulted in several State actions which have reduced available services markedly. One of the most far-reaching cutbacks was announed in December, 1970. Among the new requirements were a 10 percent cut in fees for providers of service and prior authorization for visits to psychiatrists more than once every six months. In addition psychiatric services were eliminated where the patient is not a danger to himself or others or is not in immediate peril of hospitalization.

In the view of the California Citizens Advisory Council on Mental Health, the proposed regulations ran counter to efforts of several years standing in building a mental health care system based upon outpatient assistance at minimal cost with the greatest use of available facilities. The Council also said:

> In summary, it appears that in the near term, the new Medi-Cal regulations will create a chain of events which will result in the referral of patients out of the private sector, into the County Short-Doyle system, and ultimately into the state hospital system. . . . The regulations undermine the clear legislative intent to provide equal care for all citizens regardless of economic ability, to allow the medically indigent a free choice of arrangement and to emphasize the role of preventive care and minimize the displacement from normal milieu.

The December 1970, cutbacks are no longer in effect. The 10 percent cut in fees for providers of service expired as of July 1, 1971. A Medi-Cal Reform Bill was signed into law in August, 1971, and becomes effective October 1, 1971.

Confusion is the hallmark of the Medi-Cal picture at this time, in spite of the new reform legislation. A new set of regulations under the new law will have to be promulgated; until that happens, great uncertainty will persist regarding the operation of the revamped Medi-Cal program.

There are some ominous signs on the horizon at this writing, however, as to the benefits available under the so-called reform act. One of the major restrictions of the December, 1970, cutbacks is reborn in the new legislation: physician visits—and this includes visits to psychiatrists—are limited to two per month or a maximum of 24 per year.

Language in the new statute may mitigate this two-visit requirement. Prior authorization for services beyond the two visits per month or 24 visits per year can be obtained "on the basis of an extended treatment plan where such services are medically necessary and there is a need for continuity of treatment of a chronic or extended condition." Confusion exists—will this language enable those needing regular psychiatric treatment to get the care they require? The answer may be Yes, but until the situation is clarified, confusion and anxiety will cloud the issue.

The reform act also calls for a co-payment for provider visits ($1.00 per visit) and prescription drugs (50¢ per prescription). Certain

types of income were exempted under the new law, so that it is estimated that only 50% of Medi-Cal recipients will have to co-pay. Still, it is uncertain how many will be affected by this co-payment proviso. The only certain thing is the hardship that will result from any co-payment requirement of any kind.

The Subcommittee on Health of the Elderly of the Senate Committee on Aging has begun hearings on "Effects of Medicare and Medicaid Cutbacks." Among its goals is a survey of the effect of recent cutbacks in mental health services ordered in California and other States.

II. SHORTCOMINGS IN MEDICARE AND MEDICAID

A. Medicare

GAP pointed out that Medicare recipients must still pay (1) a monthly premium (now $5.60) to obtain coverage for physician services, (2) the first $50 for doctor bills plus 20 percent thereafter, and (3) a $60 deductible for hospitalization. For an elderly couple, the premium charge alone for supplementary medical insurance amounts to $134.20 per year. This charge, by itself, exceeds the average monthly Social Security benefit of $131 for the typical retired worker.

Recognizing that Medicare is still the major system for obtaining health care for the elderly, GAP recommended far-reaching improvements to strengthen this program. Among the principal proposals:

1. Elimination of the $5.60 monthly premium charge and the 20 percent coinsurance feature under Part B supplementary medical insurance. GAP also urged that Part B should be financed under the Social Security payroll tax.
2. Elimination of the deductible requirements for hospitalization and physician services under Medicare. As an alternative, GAP suggests that a 5 percent coinsurance provision for Parts A and B may be a reasonable substitute if some form of safeguard is deemed to be necessary to protect against overutilization of health services.
3. Extension of Medicare coverage to include out-of-hospital prescription drugs and prosthetics.: (primarily eyeglasses and dentures, which are significant morale stimulants in overcoming depression.)
4. Expansion of Medicare to cover all diagnostic and treatment services. A major benefit from this undertaking, GAP maintains, is that the availability of these services would not only reduce the incentive for unnecessary hospitalization (the most expensive form of institutionalization) but would also encourage preventive care practices.
5. Inclusion of a telephone as an added Medicare benefit upon the prescription of a doctor. A principal purpose of this provision is to combat the disruptive effects of loneliness for isolated aged persons.
6. Broadening of Medicare coverage to include services of homemakers and other types of personal care—as a means of reducing unnecessary institutionalization.
7. Major revisions in Medicare coverage for psychiatric disorders, especially with regard to the 190-day lifetime limitation

on treatment in mental hospitals. Other limitations: the outpatient must pay 50 percent of the cost of doctors' service; and there is an annual limit on outpatient care of $250. (This $250, says GAP Aging Committee Chairman Robert Butler, could be completely depleted by only 5 to 8 hour-long visits to a psychiatrist who charges moderate fees. GAP sums up:

> This system not only affords inadequate coverage but promotes hospitalization rather than care in the community, often contrary to sound psychiatric practice. These limitations in coverage must be brought into line with those respecting physical illness.

GAP also points out that liberalization of present restrictions on mental illness under Medicare has been called for by the Health Insurance Benefits Advisory Council (HIBAC) of the Social Security Administration and by the American Medical Association. Specifically, HIBAC calls for Medicare coverage in community mental health centers.[36]

B. MEDICAID

Despite heavy expenditures in Federal funds for Medicaid patients, GAP charges that the money spent has not resulted in higher medical standards for elderly patients in state and county mental institutions. "In most states", GAP points out, "monies designated by law for the improvement of the care of elderly mental patients in state hospitals go into the state general revenue fund and are seldom seen by the hospitals." Labeling the utilization of funds as a "tragic situation", GAP notes that in low-income areas that disabilities frequently accumulate and illnesses remain untreated, resulting in substantial costs in terms of human suffering and socioeconomic losses.

Additionally, the report discusses difficulties in implementing the spirit of Medicaid standards. Numerous states, for example, have failed to meet the requirement that each older patient must have an "individual plan" of treatment. Approximately half of the states, it is estimated, have failed to meet other important requirements, such as the employment of a full-time social worker experienced in mental health and a part-time psychiatrist to administer and organize the program.

To help meet these problems, GAP made three major recommendations:

—The National Institute of Mental Health, together with other organizations, should press for appropriate implementation of Medicaid funds for the elderly.

—Federal funds should be made available only upon a proper showing by a state that the expenditure for personnel, equipment, and program development will improve mental health services.

—The language in the Long amendment, which authorizes Federal funding to states for Medicaid patients in mental institutions, should be clarified to remove any ambiguities.

---

[36] For additional discussion of Medicare limitations, see "Critical Issues Facing the 1971 White House Conference on Aging," A Report of the Task Force on Aging, American Psychiatric Association, in the Appendix of this report.

III. SHORTCOMINGS IN COMMUNITY MENTAL HEALTH PROGRAMS

"Action for Mental Health," the report issued in 1961 by the Joint Commission on Mental Illness and Health, has been widely praised for its insistence upon developing a wide range of community-based services and ending over-reliance upon large mental institutions.

Undoubtedly, this report led directly to the passage of the Community Mental Health Centers Act of 1963 and later amendments intended to establish a network of centers which would provide comprehensive services at the local level. (Among the five "essential" services intended to keep patients close to families and friends are: 24-hour inpatient services, outpatient services, partial hospitalization services such as day or night care and week-end care, around-the-clock emergency services, and consultation and education services to community agencies and professional personnel.)

But, even though the Joint Commission report was warmly received and its fundamental concepts regarded as progressive and overdue, it was criticized for an almost complete lack of discussion about the pressing mental health care problems of the elderly.

Concern about the elderly seems justified, in view of later developments. Morton Kramer Sc.D., Chief of the Biometry Branch at the National Institute of Mental Health, reports [37] that by 1969 persons 65 years and over—though representing about 10 per cent of the population—accounted for only 10,000 or about *four per cent* of the 250,000 admissions to services at community mental health centers. This disproportionate representation occurred despite the greater need for such services among the elderly, as compared to younger age groups.

Mr. Kramer also said:

> Because of uncertainties of the extent of future Federal support [38] for construction and staffing of these centers, it is difficult to predict their role in providing direct mental health services to the aged. If these centers are to play a major role in providing such services, considerable effort will be needed to define what this role shall be and how centers should relate to other psychiatric facilities, nursing homes, and other social and welfare services that are so essential in providing mental health and related services to the aged.

The American Psychiatric Association Task Force report reached a similar conclusion and offered additional suggestions for action:

> The role of community mental health centers is still unclear, but as one of the newest types of institutions, the development of programs in this type of institution should be encouraged. The effectiveness of any approach should be subjected to scrutiny by competent researchers, and there should be opportunities for innovation and creativity in either new programs or by the sponsorship of programs already in existence. This relates not only to the provision

---

[37] In a statement presented at the meeting of the Task Force on Aging of the American Psychological Association, Washington, D.C., June 24–26, 1971.

[38] Only $447 million was appropriated for fiscal years 1965 through 1970; 245 centers were in operation as of June 1970.

of care in the usual sense but in developing new techniques for payment. Cooperative efforts with the private and public sectors may lead to more effective utilization of facilities and more return for money invested in care programs.

Additional criticisms of the community mental health centers have come recently from the U.S. General Accounting Office[39]—which asserted that centers are not being constructed in areas with greatest need—and from Dr. Robert Dovenmuehle who—in a report to the Senate Special Committee on Aging[40]—summed up a survey of 134 centers by saying:

It is clear that in most of the Comprehensive Community Mental Health Centers, problems of the aged are not being adequately reached. The fact that few personnel have any special interest in this age group appears to be a very important factor in this since most of the centers indicated that they would like to have specialized programs and specialized personnel. It seems clear that training for community mental health center personnel in geriatric psychiatry is both wanted and needed. It is recommended that one of the proposals before the White House Conference on Aging should be an intensive program to train mental health center personnel in the care of the aged.

Discrimination Against Elderly? The lack of interest to which Dr. Dovenmuehle referred may be a common failing in the centers. Dr. Butler has complained about recent occurrences which seem to indicate a negative attitude toward older persons. In one Maryland center, for example, an elderly woman was told repeatedly that she should attempt to relate her own personal emotional problems to those of her entire family, even though she now lives in a senior citizen low-cost housing project and faces considerable difficulties in adjusting to her new surroundings. As an example of outright discrimination, Dr. Butler gives this report to him from a caseworker for a Washington, D.C. social service agency:

On Thursday, April 15, 1971, I visited Area B Mental Health Center, 1125 Spring Rd., N.W., in an effort to arrange for a psychiatric evaluation for my 69 year old client who was in an acute paranoid state. The first question asked by the intake worker was her age. I was then told that they accept no one over 60.

Center officials later asserted that this age restriction was not official policy.

Low funding levels: Symptomatic of the low priority assigned to the field of mental health are the recent budgetary requests for the Community Mental Health Centers program. In fiscal 1971, for example, no funding was requested for construction grants. In addition, the $60.1 million for staffing grants was nearly $20 million below the funding level for approved applications, and would have resulted in a serious backlog. And less than 18 percent of the Community

---

[39] In a report, "The Community Mental Health Centers Program: Improvements Needed in Management," July 8, 1971.
[40] See Appendix for complete text of Dovenmuehle report.

Mental Health Centers had special geriatric programs for elderly patients.

In testifying before the Senate Labor-HEW Appropriations Subcommittee, Senator Edmund Muskie recommended, as a very minimum, an appropriation level which would enable the National Institute of Mental Health to fund the $20 million worth of approved applications for staffing grants. Senator Muskie also pointed out:

> The Administration proposal calls for no new projects for 1971. The meaning is clear—no new services for the elderly, children, teenagers, young mothers or workingmen.
>
> When we consider the mounting stress of day-to-day living in our society today, we cannot afford to deny the care we have promised to any segment of this society.

This action helped result in a $40 million increase by the Senate Appropriation Committee, increasing the funding for staffing grants for Community Mental Health Centers from $60.1 million to $100.1 million. This figure, however, was later pared down to $90.1 million by House and Senate Conferees.

For fiscal year 1972, the Administration requested $105.1 million for staffing grants. But, no money was recommended for the construction of new centers, although $90 million was authorized. In the Senate, a $40 million increase for staffing grants was adopted to (1) eliminate the existing backlog of approved but still unfunded applications on hand at the close of fiscal year 1971; (2) permit approval of additional applications during fiscal 1972; and (3) provide for further program growth. The effect of this action was to raise funding for staffing to $145.1 million—$10 million more than the House allowance of $135.1 million. In addition, the Senate recommended $20 million for construction grants—$10 million above the House appropriation of $10 million. In Conference Committee, funding for staffing was set at $135.1 million. The appropriation for construction was eventually fixed at a level of $15 million, which would fund approximately 51 new projects.

IV. SHORTCOMINGS IN NATIONAL INSTITUTE OF MENTAL HEALTH

Both GAP and the American Psychological Association have criticized the Administration for asking low NIMH funding levels during a year which will culminate in a White House Conference on Aging. (The budget request for FY 1972 was $449.5 million, and the final Congressional appropriation amounted to $612.2 million. This compares with a fiscal 1971 budget estimate of $349.9 million, and an appropriation of $388.6 million.)

Among other criticisms are those made by Ethel Shanas, Professor of Sociology at the University of Illinois and representative of the American Sociological Association in a joint effort with other national organizations to persuade NIMH to take a greater interest in research and training programs in aging, recently said: [41]

> . . . the priority list for the National Institute of Mental Health makes no reference to the elderly. Despite the fact

[41] In a letter to Mrs. Verda Barnes, Administrative Assistant to Senator Frank Church, May 19, 1971.

that old people occupy a substantial number of the beds in our mental institutions, the NIMH has no categorical program for the prevention of mental illness in this age group.

The GAP report makes these suggestions:

1. Sufficient budget and personnel at NIMH for "effecting changes in education, in community mental health centers, and in other areas."
2. The NIMH and the National Institute of Child Health and Human Development must present more effectively the case of the aging (middle age on) before the various executive branches of the government and before Congress.
3. Substantial increases should be made in research monies for studies of aging and the elderly, from basic biological processes to social and psychological phenomena. (Although one-fourth of all annual admissions to mental hospitals comprise persons aged 65 and over, only 3 per cent of annual NIMH research funds go to the study of aging and the aged.)

V. SHORTCOMINGS—EDUCATION AND TRAINING

Intense concern about the shortage of trained manpower in mental health care programs for the elderly was expressed by GAP and by the American Psychological Association.

The APA described a "striking shortage of psychologists to serve the public through direct clinical service, to perform basic research, and to educate others." Its Task Force on Aging added:

> The magnitude of the problems related to the aging is so great that by 1980 the absolute minimum trained manpower should include 300 new academic psychologists, 600 applied psychologists, and 12,000 professional psychologists . . . The most expert projections, based upon minimal estimates, indicate that *the above estimate may be less than one-third of the actual requirement for the next decade, and that only 15 of 100 aged persons needing psychological help will be able to obtain it.* (Emphasis added.)

GAP declared:

> By the year 2000 there will be 28 million older people in America. We cannot wait any longer to institute basic changes in medical education regarding the mental health problems of the aged. One of the larger educational problems is to create favorable attitudes toward the aged. Prejudicial feelings and attitudes have to be recognized as standing in the way of this goal.

APA asks for at least a threefold increase in current funding levels for training in gerontology. GAP also calls for a greater funding effort, but also asks for far-reaching curriculum changes and other actions by universities.[42]

---

[42] See Appendix 1, pp. 152-167, for text of APA report and summary of GAP recommendations.

INTERIM RECOMMENDATIONS

The Senate Special Committee on Aging regards this report as a preliminary survey, rather than a definitive study.

Its recommendations, therefore, are limited to those actions which can and should be taken before the White House Conference on Aging, or soon after. They follow:

Legislation should be introduced at an early date to call for a Presidential Commission on Mental Illness and the Elderly American, to work with administration officials having responsibility for implementing recommendations made at the White House Conference on Aging. Every effort should be made to involve the private sector, including nonprofit national organizations, foundations, medical schools, and private organizations.

Discussion: Critics of the Joint Commission on Mental Illness and Health have pointed out that the Commission report in 1961 paid little attention to the special problems of both youth and the elderly. As far as children are concerned, the deficiency was somewhat filled with the establishment of a Joint Commission on Mental Health of Children in 1965.

For older Americans, however, the deficiency still exists. As even this preliminary report indicates, however, the issues related to mental health services for the elderly are numerous and complicated. In addition, the many new developments in the field are occurring at a rapid pace. As one state decides to limit entry by age into state hospitals, another may decide to accelerate discharges, for example. *At a time of such accelerated change, it becomes increasingly difficult to determine what is actually happening to those persons who are directly affected by such experimentation.*

A Presidential Commission, if given adequate funding and staff, could do more than just "conduct a study." It could, and should:

1. Make close contact with those representatives of the Executive Branch who will be charged with carrying out recommendations made at the White House Conference. Arthur Flemming, Conference Chairman, has said that implementation will begin on the very day that the conference ends. A Commission should therefore be in existence at that time, or soon after.
2. Establish work and investigatory relationships with Congressional units now looking into issues and programs related to both health and aging. Wherever possible, Congressional hearings should be conducted in complete cooperation with Commission programming of activities.
3. Begin early inquiries into the exact status of "Long Amendment" funds under Medicaid.
4. Issue questionaires and take other action to determine how many persons are being affected by publicly-supported programs intended to reduce populations at institutions in one way or another.
5. Issue a preliminary report at an early date, calling for intensive inquiries into priority issues.

As has already been suggested, legislation calling for such a Commission should be introduced at an early date in order to indicate to

69-261 O - 71 - 3

participants in the White House Conference that a mechanism for helping to carry out their recommendations could be established in time to be of practical usefulness.

This recommendation by the Senate Committee on Aging is similar to a GAP proposal calling for a Presidential Commission on the Mental Health and Illness of the Aging and Retired. In urging passage of an "Aging and Retirement Mental Health Study Act," GAP said that the Commission to be created by that act must be nongovernmental and multidisciplinary, including professional and lay groups. It called for "adequate funds and powers to award grants under the administration of the National Institute of Mental Health as well as the Administration on Aging.

Among the questions which GAP wishes the Commission to explore are:

1. What will be the needs in manpower, in facilities, and in research?
2. What can older people themselves do to prevent illness.
3. What will be the costs to our society now and in the future? How shall we meet those costs?

Above all, the Commission would make recommendations toward a comprehensive national policy for the prevention, care, and treatment of mental illness" among the aging and retired population of the United States.

Recommendations for broadened Medicare and Medicaid coverage—advanced by GAP, the American Psychiatric Association, the American Psychological Association, the President's Task Force on Aging of 1970—and others should be analyzed by the Social Security Administration and other appropriate Federal agencies. Cost estimates should be produced, in time to be of assistance to participants in the White House Conference on Aging, and to assure rapid implementation of Conference recommendations.

Discussion: Preliminary workbooks for the White House Conference on Aging made only passing mention of proposals to improve coverage under Medicare and Medicaid. And yet, because of the importance and urgency of the issues involved, it is vital that participants at the conference have essential information on costs of proposed improvements. Such estimates will be useful, too, in future discussions of proposals to establish a national health insurance system.

It will do little good, however, if such estimates do not reflect cost reductions that could occur with improvement of existing services and a greater emphasis upon preventive programs. The Social Security Administration has already produced estimates of hypothetical savings that could occur if certain chronic illnesses were reduced or eliminated. An attempt should be made to provide the same kind of evaluation in the field of mental health.

Consideration should be given for institution of a national personal care corps capable of helping elderly persons remain in their homes, or be better served in hospitals and nursing homes.

Discussion: This proposal, also advanced by GAP, was prompted by serious shortages in the varied categories of medical aides available for the care of the elderly in their homes. GAP said that:

1. In 1967, an estimated 200,000 home health aides were needed, but only 6,000 were available.

2. Medicare pays for up to 100 home health visits per year, but only one of seven Medicare patients lives in an area where such services are available.

In calling for a "massive federal health-at-home manpower and training program," GAP said that such a program could produce workers capable of performing "many of the functions that are now inefficiently spread over existing categories of visiting nurses, home health aides, occupational therapy assistants, and others."

By helping to keep the person at home, the Corps would contribute to that person's well-being and would prevent needless institutionalization, which so often takes the form of commitment to a state mental hospital.

The present administration, when called to testify upon a bill calling for a national Older American Community Employment bill, said that the legislation was unnecessary because its programmers were working on preparations for a comprehensive program which enlist large numbers of older Americans.[43]

In its deliberations, the administration should consider inclusion of the Personal Care Corps concept for those participants who will be paid for those services. For those participants who wish to serve as volunteers, the new ACTION agency [44] should offer a proposal, in the near future, which would put special emphasis on the provision of personal care.

Representatives of national organizations with an interest in aging and mental health will participate in the White House Conference on Aging, and they should use the occasion to develop a statement of mutual purpose on priority issues for the 70's.

Discussion: Many individual statements from authoritative organizations (GAP, American Psychological Association, American Psychiatrict Association, for example, in statements quoted extensively in this report). But comparatively little has been said about what each private organization can or would do as part of a unified effort. Such a statement would have special relevance to a "Special Concerns" session scheduled on December 1 from 8 A.M. to noon for the discussion of "Emotional Problems of Aging." The American Association of Medical Colleges should be invited to participate. One area in which national organizations can be of special help is in the matching of needs in their specialities with the actual skills that may be available among retirees and others.

---

[43] "Employment Opportunities for Middle-Aged and Older Workers, S. 555, S. 1307, S. 1580"; Subcommittee on Aging of the U.S. Senate Committee on Labor and Public Welfare; July 29 and 30, 1971; hearings are not yet in print.

[44] ACTION came into existence in June, 1971 after the House and Senate failed to pass a resolution H. Res. 411 and S. Res. 108 to disapprove Reorganization Plan No. 1. The following programs have been transferred to ACTION:

1. Volunteers in Service to America (Formerly under the direction of the Office of Economic Opportunity);
2. Foster Grandparents (Previously under the Administration on Aging);
3. Retired Senior Volunteer Program (Formerly administered by the Administration on Aging);
4. Service Corps of Retired Executives (Originally sponsored by the Small Business Administration);
5. Active Corps of Executives (Previously administered by the Small Business Administration); and
6. Auxiliary and Special Volunteer Program (Originally sponsored by OEO).

PART TWO

ACTION PROGRAMS TO PREVENT, REDUCE, OR IMPROVE INSTITUTIONALIZATION

INTRODUCTION

By WILMA DONAHUE, Ph. D.*

Almost a decade ago, participants in the White House Conference on Aging called for consideration of "certain positive concepts" which would help provide for mental health needs of older people.

Their call for action was based partially on the growing realization that there was then no real agreement, even among specialists in the field, upon goals that should be sought to provide alternatives to institutionalization of the elderly, or to make institutionalization more effective for those who must have such care.

In short, the concept of reversibility of mental illness among the elderly was then just beginning to take hold. It was realized that not every elderly person could be helped to overcome illnesses of many years duration; but it was also recognized that we in this Nation had an almost fatalistic acceptance of mental disability among the elderly.

An old person in an institution—whether he had grown old within those walls or had entered the hospital or nursing home during his later years—was regarded as a low priority patient. Worst yet, he might be regarded as "senile" or "hopeless" for some ill-defined reason.

The White House Conferees of 1961 asked for the following actions:

1. The development of a public enlightenment program which recognizes that public attitudes toward mental health can and must be changed. This process of enlightenment should begin with the child in the family and continue throughout life.
2. That the mentally ill aged should receive service in the community from the same agencies and clinics serving other groups.
3. The aged should receive mental hospital service only when they are mentally ill and there are psychiatric indications.
4. Mental health services, in-patient and out-patient, should be organized to allow free movement of patients between services depending on treatment needs.
5. The community should provide a proper psychiatric evaluation of any patient prior to initiating commitment proceedings. If commitment is indicated, plans should be started immediately toward return of the patient to the community. The procedure of commitment should not require a finding of incompetency.
6. Any plans which provide health care or assistance should not exclude the mentally ill. A percentage of all Federal hospital construction funds should be earmarked by the States for mental health facilities.

*Technical Director, 1971 White House Conference on Aging, and former cochairman, Institute of Gerontology, University of Michigan, Wayne State University.

Since 1961, the "positive concepts" expressed above have been fulfilled in only limited fashion.

A Mental Health Centers program *was* authorized by Congress and it now is at work in hundreds of communities. But, in terms of everyday helpfulness to the elderly, its record thus far is spotty at best.

Medicare and Medicaid *were* enacted within four years after the White House Conference, but—as documented elsewhere in this report—both programs are crippled, as far as mental health is concerned, by a retrogressive concept of care requirements.

The Older Americans Act *was* passed in 1965, and one of its stated objectives was to encourage "full restorative services for those who require institutional care." Welcome as funding from that source has been for certain valuable purposes, passage of the Older Americans Act has not yet led to a coherent national policy for the purpose described in the act itself.

In addition to legislative enactments, the near-decade has also brought individual pilot projects intended to prevent institutionalization by careful screening, to help those who are capable of leaving State hospitals and return to the community, or to improve care for those who must remain in hospitals or nursing homes. Several such projects are described later in this report. As one who has been associated with the Ypsilanti program (See pp. 33–50), I have good reason to be heartened by what can be done when talented and sensitive staff grapples with the formidable problems related to mentally ill old persons who have years or even decades in a hospital.

But I am equally aware that such projects remain just that—isolated islands of progress which help the relatively few elderly who are fortunate enough to be served by them. And so it shall continue to be unless there are profound changes in attitudes and priorities among the professional community toward the rehabilitative capacities of the elderly ill. And unless there is a new and strong national commitment to insuring that the mentally ill old are not abandoned to the desolation of a meaningless existence either within or outside an institution. Prevention of mental illness among the elderly must become a prime target of all mental health programs for this age group. We must establish community mental health programs which not only provide direct help to the elderly, but which also work to make the community a more livable place for them. Financial help must be just as available for the care and treatment of mental illness as for physical illness. This means improvements and specific changes in Medicare and Medicaid.

Many proposals for such purposes are suggested on the pages that follow. It is my firm hope that those proposals will make a contribution to the dialogue which will take place at the 1971 White House Conference on Aging. We know much more about mental illness of elderly persons now than we did when the 1961 White House Conference recommended specific actions. We know that physical illness is very often the basis of mental illness and that treatment must begin with correction of the physical disability. We know that to evict the elderly mental hospital patient and rehouse him in a nursing home or similar institution where only minimal physicians' services and no psychiatric services are available is not good social or medical practice.

We know that while the inclusion of older people in the community service programs serving all age groups seems sound in principle, in practice the elderly do not compete successfully for these services. Because we know these and many other new things, we should now be able to develop a clearcut set of policies which will achieve the goals to which we aspire.

PROJECT STUDY ONE*

YPSILANTI STATE HOSPITAL: MILIEU THERAPY AND RE-ENTRY INTO THE COMMUNITY

Ypsilanti State Hospital is typical of mental institutions built during or soon after the 1930's. Distant from urban centers, its red-brick buildings sprawl over many acres. In its long, hall-like "day-rooms" young and old patients pass uneventful hours; many stare at nothing, not even the television mounted above their heads on brackets in corners; some spend their days sleeping on the benches or on the floor. Approximately 1,200 Ypsilanti patients are elderly, and many of them are the most withdrawn of all.

But in two wards, patients in the 50's, 60's, 70's and even beyond are snapping the bonds of inertia, hopelessness and fear. They are participants in a "therapeutic community" which has proved to be, for many, a road back to independent life—with specialized help, to be sure—in the world outside the institution.

INNOVATIONS:

1. "DE-INSTITUTIONALIZED" DORMITORIES THAT ALLOW FOR PERSONAL CHOICES AND TASTES.
2. EMPLOYMENT, WHICH OFFERS PAY FOR ASSIGNMENTS CONTRACTED FROM NEARBY INDUSTRY.
3. A SELF-GOVERNED "MILIEU" WHICH IS A COMMUNITY IN ITSELF, COMPLETE WITH RETAIL STORE AND GIFT SHOP.
4. PERSONNEL WHO HAVE RESISTED THE TRADITIONAL AUTHORITARIAN-CUSTODIAL ROLE—WHO DRESS IN STREET CLOTHES AS THE PATIENTS DO.
5. AND, IN NEARBY DETROIT, "OPERATION FRIENDSHIP", A SOCIAL AGENCY WHICH PROVIDES SERVICES AND SUPPORT NEEDED FOR A SUCCESSFUL RETURN TO THE OUTSIDE COMMUNITY.

*The following six project studies were prepared by Miss Dolli Cutler while a member of the staff of the U.S. Senate Special Committee on Aging. Miss Cutler is now with the U.S. Administration on Aging.

ONE: THE STATE HOSPITAL AND THE ELDERLY

Most mental hospitals in the United States provide adequate custodial care and, nominally, conduct some therapeutic activities for geriatric patients. But the patients rarely participate in any decisions affecting their welfare. Traditionally, the climate on a ward is authoritarian. Nurses and aides give orders; the patients, when they are not too disturbed or uninterested, obey. There are few if any, person-to-person relationships between patients and staff or among the patients themselves, most of whom seem sunk in apathy. The better-oriented patients may have ground privileges or perform some kind of work for the hospital. At intervals they may be conducted to another building for a recreational or occupational therapy program. In some hospitals, a recreational or occupational therapist may come to visit the ward. But these activities usually are interruptions in the life on the ward, rather than integral parts of it.[1]

This is not true in two wards at Ypsilanti State Hospital in Michigan. There, the milieu therapy treatment wards are meant to provide a replica of the outside community. The purpose is to provide the patients with a functional, structured society, offering differing roles, status, a set of values, and a system of rewards.

At Ypsilanti, the treatment is based on an expectation of the patient's eventual return to the community. When a patient improves with hospital treatment, a professional representative from an agency in the community is brought into the hospital to become familiar with the patient's problems and help plan for his release. After discharge, the agency continues to provide support and follow-up in the community.

In short, the Ypsilanti plan brings the community into the hospital and the patient to the community.

THE THERAPEUTIC COMMUNITY

Like the community outside the hospital, the therapeutic community has a physical nature:

—In the hospital ward, rooms and hallways take the place of buildings and streets. Doorways are brightly painted. Notices of current events—outside as well as within the hospital—are posted on the walls.

—The day room resembles a normal living room, with attractive and colorful furniture arranged in conversational groupings.

—Bedspreads are of different colors; and there are curtains at the windows, full length mirrors, clocks, calendars and pictures on the walls.

—The patient's bed and chest become his "home". He is encouraged to "decorate" as he likes, using personal items from the past, including family pictures and colorful pillows. He is also expected to take care of his belongings and keep his "home" neat and clean.

—The ward staff dresses in street-clothing rather than the traditional hospital uniform.

---

[1] The Committee is indebted to Miss Olivia Coulter, Editor, "Aging" for her draft of *A Model for Integrated Hospital Community Program for Older Mental Patients*, 8-8-68, from which much of the information in this portion of our Report was taken.

—Doors are unlocked and patients have freedom to come and go within the ward, but they must still go through routine procedures to leave it and meals are scheduled at set times.

Thus, the patient assumes the role of householder and neighbor. He takes a first step toward reassuming responsibility for himself.

INTRODUCTION TO THE WARD—THE TREATMENT PROGRAM BEGINS

A special effort is made to establish a supportive, friendly atmosphere for each new patient in the milieu therapy ward.

First, he is welcomed by the nurse in charge and shown to his bed and chest. After a "place of his own" has been established, he is taken on a tour of the entire ward: the industrial therapy shop,[2] the ward store, patient kitchens, the laundry and ironing room, and storage room for supplies, he learns about the activities carried out in each room and is assured that he, too, can use the rooms for the same purposes. The staff is introduced, as well as patients, informally, a few at a time. The new patient is encouraged to visit any patients he might already know. Finally, he is invited to join an activity,[3] but he is not commanded to do so.

CASE STUDY: Mrs. A. was transferred to the milieu therapy wards after having been a patient at Ypsilanti for seventeen years. She had a previous history of hiding from staff and patients, and refusing to eat.

The first day on the ward, she was taken on the usual introductory tour, and while visiting the workshop, expressed an interest in the toy poodles some of the patients were making. She was invited to join in this activity. She adapted very quickly to the workshop and began to make friends with her fellow workers. Within a month, Mrs. A. asked if she could work in the ward store and soon became one of the best storekeepers in the ward.

(A few months later, she moved out of the hospital, and Operation Friendship [4] helped find a family for her to live with. It was an ideal arrangement with an older couple; the husband was ill and the wife needed a companion. Mrs. A. has been very happy in the community, has attended the Operation Friendship programs, and recently found she "had too much free time". (She now has a part-time job in downtown Detroit.)

The above is one of the "success stories". Of course, not all of the patients are so successful.

But it is important to remember that Mrs. A.—a patient in a State mental hospital for *seventeen years*—is now living a satisfying life in the outside world.

THE ROLE OF WORKER

The patient is introduced to the industrial therapy (also known as the "Gericrafter" workshop) workshop as soon as possible after he

---

[2] See pp. 35–37 for details on Industrial Therapy Workshop.

[3] Usually, the workshop; and while the patient develops self-confidence from this type of activity, he also makes friends in his work group and on the ward, thus joining recreation programs and social groups as his emotional strength returns.

[4] See Operation Friendship, p. 42.

enters the ward. The workshop is a large, well-lighted room, where the patients work at a wide range of jobs, for which they are assigned varying pay levels, depending upon the difficulty of the task.

> **One of the most innovative aspects of the workshop is the alliance the milieu therapy wards have formed with outside industry. For example, a group of workers assembles small parts for one of the automobile giants located in Detroit, and the workshop is paid for each contracted job lot.**

The workers also fashion toys, jewelry, hooked rugs and stuffed pillows for sale in the ward gift shop, which is run by patients for hospital visitors and staff. A number of the gift items are also sold in gift shops and street fairs in the outside community (in nearby Ann Arbor and Detroit).

Through such contacts with outside industry and business, the industrial therapy workshop becomes a means for supporting the cost of providing salaries to patients for the work they do, and therefore the roles of worker and earner are realistic.

Another ward store has opened recently, also run by patients. Here, patients may purchase both new and good used clothing. This new addition to the milieu therapy wards has proved to be most successful, and has made considerable difference in the patient's grooming and care of clothing. It has also almost erased the use of state-issue clothing on the wards.

The position of store manager is one of the most responsible on the ward. The manager must handle and account for money and shop for items in the outside community for resale in the store. Usually, another patient serves as stockman and clerk during "rush hours" or when the manager must be absent on other duties.

A number of jobs are available outside the workshop, which are also rated as to difficulty and for which the workers are paid hourly rates or salaries. Some of these include: ward maintenance, meal service, operation of the ward store and gift shop, bookkeeper and paymaster.

As the patient succeeds and gains in self-confidence, he is promoted to higher pay levels and more difficult tasks. Quite often, the patients themselves suggest that they are ready for a move up.

Some jobs, such as store manager, are salaried; and bonuses may be awarded for specific work responsibilities that are not easily classified in the hourly rate system. Some of the faster workers are paid on a piece-work basis.

Payday occurs every other week and each worker receives a pay envelope with a limited amount of money—approximately $5—in it. Any amount earned beyond that is issued in the form of a receipt redeemable at any time. The patient-workers are allowed to deposit any savings from their pay in the ward office, with the paymaster, who issues deposit books so the patients may keep a record of their savings. Many patients, instead of depositing their savings in the ward office, chose to open savings accounts in the local bank in the outside community.

No matter what method of savings the patients use, most of their funds go toward the purchase of clothing (and household items for

those released to independent living arrangements) they will need when they are released from the hospital. As their savings grow, so do the patients' hopes for eventual discharge into the outside world.

The milieu therapy ward also grants loans to the patient-workers, which they pay back from their paychecks. A patient might ask for a loan to go on a field trip into the community for shopping, or for plays, concerts and movies.

THE PATIENT AS CONSUMER

The patient first assumes this role at the ward store where he can purchase cups of coffee, soft drinks, snacks and other items ordered for the store upon the patient-customer's request.

As the treatment progresses, more and more patients offer to sell services or products to the other patients. Some of the services offered include: ironing, mending and dressmaking, cooking, hair-styling, etc. As the patients improve, they are taken on shopping trips into the community by members of the staff, and finally given permission to go by themselves or with another patient, when it becomes obvious that they can handle this type of activity. Through such excursions patients build up the social skills they will need when they return to the outside community.

It has been found that such visits to the community motivate patients to improve their personal appearance more than any amount of exhortation by the staff.

THE ROLE OF FRIEND AND GROUP MEMBER

As has been stated earlier, patients working together develop social skills by working with a group or team. They also develop strong loyalties to each other, at work and during leisure hours, at parties and other programs.

A self-government group was set up for improvement of the ward and its programs. The governing council also discusses "problem" patients (a patient who might be creating difficulties for the other persons on the ward) and tries to work out solutions that will benefit the entire ward, as well as the patient in question.

For example, one of the women on the ward was "hogging" the kitchen so that none of the other patients could use it. She loved to bake and to cook. The Council voted that any patient who wanted to use the kitchen had to sign up for a specified time allotment and arranged for the lady in question to be able to sell her bakery goods in the ward store. Thus, the "problem" patient was given a role of greater importance on the ward, and the other patients were then able to use the kitchen.

Every patient has a "day off" every other week. This means that every day there are approximately fifteen patients with free time on the wards. These patients are split into two social groups and they can go out into the nearby city on shopping trips, to a movie, visit museums, etc., or they can join social activities on the ward, such as the bridge class, drama club, TOPS Club (Take Off Pounds). The

social groups have become an integral part of the milieu therapy program and have proven extremely successful as a means of helping patients relate to one another and preparing them for life in the outside community.

THE WARD POPULATION—PATIENT AND STAFF

Two milieu therapy wards at Ypsilanti now house 160 patients (80 men and 80 women).

In order to create a social structure similar to the outside community, every effort is made to avoid segregation of men from women patients. They work together, join each other for recreation, and go on shopping trips into the nearby city together. Thus, another fear of the outside world is broken down and the patients are more able to handle real social situations upon their release from the hospital.

The geriatric patients selected to participate in the Ypsilanti Project are ambulatory and able to communicate.[5]

> **A majority of these patients have been in the hospital for many years, and have actually grown old in the institution. Some had been hospitalized for as long as twenty years. A number of new patients (those who have been in the institution four years or less) were included to give the Project a good cross section of the aging patient population.[6]**

The milieu therapy wards have the following staff:

- 2 registered nurses
- 7 attendants
- 1 part-time psychiatrist
- 1 social worker
- 1 industrial workshop superintendent
- 4 group workers (University of Michigan staff)
- 2 industrial therapists (ward staff) [7]
- 1 program director (University staff)

Each ward has three attendants on the afternoon staff and two on the midnight (midnight through noon) staff.[8]

At regular staff meetings, staff members try their hands at role-playing, to better understand how to deal with situations.

For example, a patient on the ward has been resisting involvement in activities and the staff feels he is not making progress. During the staff meeting, one member takes the role of the "patient" and acts out how he feels the patient is (or is not) responding, while another of the ward personnel acts out the role of "staff member". The other staff members offer suggestions and criticisms. The staff can thereby gain more understanding of what it really means to be a mental patient.

Students (taking their training on the Milieu therapy wards) also join in staff meetings, to discuss fresh ideas for new types of patient activities on the wards.

---

[5] It should be noted here that a number of homes for the aged across the country have introduced a form of milieu therapy for patients who are not ambulatory, with an encouraging degree of success.

[6] One-third of the patients had been admitted during the previous four years and two-thirds had been hospitalized for more than four years.

[7] Industrial therapists from University staff were used briefly, to train ward staff in order that they might run the "Gericrafter" Workshop on their own.

[8] In written communication from Mrs. Dorothy Coons, Project Director, Ypsilanti State Hospital 1/24/69.

At first, the hospital staff had to take responsibility for the custody and maintenance of the patients, but as the therapeutic community matured, patients were able to take on more responsibility.

The staff soon recognized that their role had changed from an authoritarian-custodial one to one in which they acted as therapists, helping patients make their own decisions. Ultimately, the patients take over many of the staff's previous duties, such as, mail distribution, clerical work (typing, filing), making calls to outside agencies, taking cash and going out to purchase supplies, and teaching.[9] Some patients are also being trained to act as tour guides for visitors and students.

A new and interesting development has been the establishment of patient-staff panels, who discuss the milieu therapy treatment program in presentations to psychology, and social work classes at the University of Michigan Institute of Gerontology. This project has been described as very successful. Indeed, some of the patients are so articulate that they "steal the show" from the professionals.[10]

DISCHARGE AND PLACEMENT PLANNING

When an elderly person is considered ready for discharge, the traditional hospital makes contact with his family, or with an agency in the community, to arrange for placement. Arrangements with the Social Security Office or local welfare department are made for the patient to receive the funds due him and any assistance he needs. Oftentimes, the community welfare department offers social services to discharged mental patients; but this varies from State to State and even within a State, depending upon the resources a local department might have available.

In contrast, the Ypsilanti Project brings the community into the hospital to become familiar with the patient and his needs *before* his release to work toward development of an adequate living arrangement, plus social contacts and activities on the outside.

When planning begins for a patient's release from Ypsilanti, a representative from a community agency [11] (which works closely with the staff) is brought into the hospital to attend staff meetings in which the patient's progress and continued treatment outside is discussed. At these meetings, the representative is briefed on the patient's emotional, financial, medical, and social needs so that the agency may give him essential support and assistance. The representative is also valuable to the hospital staff at this time because of his knowledge of what is and what is not available for the soon-to-be released patient in the world outside the hospital.

Some patients need greater attention than others. For them, a nursing home, or home for the aged may be best; others may function better in a foster home or a room-and-board situation. Those persons capable of living independently occasionally team up with another patient to cut costs.

---

[9] Patients actually teach handicrafts to students and staff personnel from nearby hospitals. This is an especially stimulating experience for those personnel from the other wards at Ypsilanti, who find themselves being taught by former patients.

[10] Written communication from Mrs. Dorothy Coons, project director, Ypsilanti State Hospital, Milieu Therapy Program, January 13, 1971.

[11] A social welfare agency from nearby Washington County works with the hospital in placement planning for that county, but the most extensive work is done by Operation Friendship, in the Detroit area.

Shortly before release, those patients who are found capable of independent living, review nutrition facts and menus, practice such seemingly simple skills as using a dial telephone and the utilization of public transportation.

Those patients who will have to continue taking medication are placed in a "domiciliary care" program several months before release from the hospital, where they are allowed to order their prescriptions from the hospital pharmacy and take the prescribed dosage without supervision. In this way, the staff learns whether the patient understands the importance of taking the medicine and if he can be depended upon to continue taking it after release.

As the day of release approaches, the project social worker takes the patient on site visits to each of the available living arrangements. After he returns to the hospital, the patient gives his reactions to the accommodations in an interview with the staff social worker.

If after his release, the patient finds the living arrangement unsatisfactory, or if his needs change, the community agency may provide an alternative accommodation, rather than returning the patient to the hospital ward.[12]

Operation Friendship of Detroit has a regular social activity and group therapy program for those patients who plan to live in that city. They attend just before and after their discharge, thus providing a smooth transition to the outside world.

SOME SIGNIFICANT RESULTS

The Division of Gerontology, University of Michigan, developed the milieu treatment program for the elderly mental patient at Ypsilanti State Hospital and has completed three research projects thus far which compare the effects of the "community" milieu with a more traditional, custodial milieu.

It was found that the "community" milieu easily surpassed the traditional in helping patients adjust to the demands of a non-hospital environment.

—During the year following treatment, the community milieu discharged slightly less than one-half of its patients; whereas the traditional milieu was able to discharge only 25% or one-fourth of its patients.

—Upon discharge from the hospital, the majority of the patients from the traditional milieu were placed in supervised room-and-board settings, while the patients from the community milieu were placed in a variety of settings with a greater opportunity for self-sufficiency.

—Further, 19% of the community milieu patients could move into apartments, while *not one of the traditional milieu patients could be placed in such independent living situations.*[13]

It appears, therefore, that two important results of the community milieu therapy program have been to increase the number of patients discharged from the hospital and to provide the opportunity for such persons to assume independent living status in the community.

---

[12] For an example of placement change, see Operation Friendship, p. 42.

[13] Abstracted from University of Michigan, Division of Gerontology—21st Annual Conference on Aging—"Description of Some Research Findings from the Therapeutic Milieu Project" 1968.

The Ypsilanti Project, has been confronted by a frustrating problem—that of suitable placement in the community upon discharge and adequate income for the patient to make discharge possible.

Most of the patients involved in the milieu therapy program, as was mentioned earlier, had been hospitalized for many years. *The average length of hospitalization was fourteen years.* They are also for the most part, poor people, without the income to assure them easy access to good housing. For those patients who are emotionally able to move into apartments, it is extremely difficult to find good, comfortable, independent living arrangements at a feasible cost. Thus, even though some of the patients were able to take on independent living situations, very few could be accommodated.[14]

Although State mental hospital patients in Michigan are technically citizens and can vote [15] they are restricted from entering into contracts and cannot have a driver's license. Once a patient is discharged from the hospital, it takes from two weeks to a month to have his legal rights restored. Placement planning begins weeks before the patient is released from the milieu therapy wards and those patients who are able to move into apartments must have their legal rights before they can sign a lease. However, legal rights cannot be restored until the patient is out of the institution; and this presents an almost impossible obstacle in finding independent living arrangements. The problem has been overcome to some degree by the community agency and the welfare caseworkers who work diligently to find responsible legal guardians who can sign apartment leases for the patient. As was stated earlier, most of these individuals have little or no income; therefore, it would seem that public housing would be an ideal situation for them. Unfortunately, *because they are unable to sign a lease, not one of the patients discharged from the milieu therapy wards have been accepted by Detroit's public housing authorities.*

For those patients ready for discharge who need a more supportive living situation, such as nursing homes, homes for the aged, foster homes and room-and-board houses, similar difficulties exist. There are not enough of these facilities, and those that do exist are often inadequate.

For example, recently, one of the discharged patients returned to Ypsilanti—on her own initiative—after one day away from the hospital. She had been placed in a boarding home and the first evening the director told her, "Television goes off at 5:00 p.m., and I don't want to hear from you until 7:00 a.m. tomorrow morning." The next morning she appeared back at Ypsilanti, suitcase in hand. She explained, "Here at Ypsilanti, I found out I don't have to live like that—and I refuse to."

SUMMARY: HOSPITAL PHASE

All of the recent statistics demonstrate dramatically the magnitude of the problem of mental illness among the elderly—but, as a noted

[14] See Operation Friendship, p. 45 for an explanation of this placement problem.

[15] Patients are legally able to vote while in the hospital. However, a person must vote in the township of his residence and most of these patients have been in the hospital for a number of years and have no "residence" but the institution. In many cases, the patient's old neighborhoods and even some townships, no longer exist. During the last Presidential elections, the milieu therapy staff took several patients to the polls as a "test case". None were allowed to vote.

69-261 O - 71 - 4

expert in the field of geriatric psychiatry has said, "we will not solve that problem unless we can first convince ourselves that something can be done about it." [16]

The Ypsilanti Project has proved that something can be done:

—The "community-like" environment of the ward, upon which the treatment program is based, increases the likelihood of discharge from the hospital to the outside community.

—The differing roles offered the patient, each with its system of rewards, prepares him for a new life, outside the hospital.

—By taking the patient to the community (field trips, shopping excursions, etc.) and bringing the community to the patient before release (community agency), fear of the outside world diminishes to the point where he can once again become a functioning member of society.

The most dramatic proof is that elderly mental patients who had spent years in a State institution are now able to lead productive, independent lives—some of them seeking and finding employment in the community.

TWO: THE COMMUNITY—OPERATION FRIENDSHIP [17]

What discharged mental patients need most of all, if they are to remain outside the hospital, are knowledgeable people in the community who can provide both the understanding and the time to redevelop social skills. In other words, the discharged mental patient must feel that someone in the outside community cares about him.

To the elderly patients in Ypsilanti Hospital's Milieu Therapy wards, Operation Friendship provides such a service—and more. The Center also acts as a placement service for elderly discharged mental patients; its workers go into the hospital before release to work with staff personnel and the patients themselves. Then, they take the patients on site visits to help them choose the most comfortable and convenient living situation.

THE ESTABLISHMENT OF A SOCIAL AGENCY FOR EX-MENTAL PATIENTS

Among the membership of the Detroit Section, National Council of Jewish Women, are several housewives with prior experience in social services of one kind or another. Like so many such women, they found that after their children had grown, they wanted to put their knowledge to constructive use.

After conducting a survey of areas of need in the Detroit community, the organization found that ex-mental patients had practically no one to help them return to the community. The few agencies that did serve mental patients were for the most part, inadequate; and the hospitals had neither the budget nor the staff for the kind of extensive follow-up that is so necessary for a successful return to the "outside world."

[16] In "Mental Health Services for Older People", George James, MD, Dean, Mt. Sinai School of Medicine, New York—"Geriatrics," May, 1967.

[17] The Committee is indebted to Mr. Adolphus D. Waugh, Project Director, Operation Friendship until April 7, 1970, for much of the information in this portion of our report.

Thus, Operation Friendship began in January, 1960, operating from a retail store that had been converted into a lounge and workshop.[18] The primary purpose of the new agency was that of a social service to adult ex-mental patients (of all adult age groups), recreation and re-orientation being the major themes of the service.

The Center resembles a social club. Patients are called "members" to give them a sense of belonging in the community. No fee is required for participation and all food and crafts supplies are provided without charge to the members.

Volunteers are trained by a professional staff of social workers to work with the "members" who require special help. The volunteers meet in regular group conferences with the professional staff [19] and their training continues throughout their service at Operation Friendship. Each year a program of lectures and field trips is organized by the Volunteer Council for new participants. As lay people, the volunteers offer the discharged patients an opportunity to identify with the community positive attitudes of acceptance and interest.

In addition to the adult volunteers from the National Council of Jewish Women, there are volunteers from the Central Methodist Church, the Archdiocese of Catholic Women and several student groups from nearby colleges.

AN ACTIVITY PROGRAM THAT IS VARIED AND MEANINGFUL

Each member of Operation Friendship may participate in all levels of the activity program, or move at his own pace, from one to another.

To promote a feeling of belonging, each activity is a "club meeting." Included, is a Monday Afternoon Club, Monday Evening Club, Tuesday Club, Thurdsay and Friday Clubs, and a Sunday Club. The club activities include: sewing, chess, volley-ball, films, dancing, outings, handicrafts (the handicraft club is the ongoing project for Children's Hospital), discussion of current events, cooking, publication of a newsletter and participation in the Interclub Council. Approximately 25–30 members, at least one professional staff member and six volunteers attend each club meeting.

The "members" are referred from Lafayette Clinic, Detroit General Hospital, Eloise, Northville, Adult Psychiatric, Henry Ford Hospital, Ypsilanti State Hospital, private general hospitals in the area, as well as from physicians, psychiatrists and social caseworkers. Those persons who are considered potential hospital patients are also admitted to membership.

Operation Friendship arranges for appointments at health care facilities for members; volunteers meet them at the Clinic and remain with them until the appointment is completed. In some instances, individual case work service is also available.

---

[18] Operation Friendship has moved twice to larger quarters, and is now housed in a converted one-story office building. All of the fixtures and furniture in the Center were donated by the Volunteer Council.

[19] The professional staff consists of four social workers whose primary function is to work with referral agencies and to train volunteers. However, they also work with the patients and generally stimulate an atmosphere that encourages members to help themselves on their way back into society. In addition,13 graduate social work students as well as several undergraduate students, are receiving their field work training at Operation Friendship. The staff also has the support of a monthly conference with psychiatric consultant, and a group social worker consultant.

AN ATTEMPT TO ANSWER A GREATER NEED—PROJECT OLDER AMERICAN

Operation Friendship had been very successful as a social agency for mental patients of all adult ages. However, the volunteers and staff had become increasingly aware of the special needs of those mental patients 60 years and older. Many of these individuals had lost family ties and friends during their long years in the institution and had little income with which to start anew outside the hospital.

Housing was a special problem for these older patients; and there was a need to explore existing possibilities in the areas of appropriate housing and perhaps, to create new kinds of housing arrangements for such persons.

Early in 1966, Dr. Wilma Donahue, Chairman of the Division of Gerontology, University of Michigan, called planning meetings with staff and members of the State Commission on Aging. They decided to draft a proposal for a demonstration project, whereby:

—Operation Friendship would find housing in the community for elderly rehabilitated mental patients referred by the milieu therapy project at Ypsilanti State Hospital;

—It would involve them in social groups at the Operation Friendship lounge, as well as maintain a liaison with the patients and/or with their social worker if referrals to other community agencies (such as health care, welfare, etc.) were indicated;

—That same year, the State Commission on Aging considered and approved a thirty-six month demonstration project—the first such agency in the State of Michigan to receive a grant from the Older Americans Act.[20]

The older patients from the Ypsilanti Milieu Therapy Wards are encouraged to participate in any of the ongoing activities at the Operation Friendship Center. No attempt is made to separate them from the other "members" because of their age.

WANTED—COMMUNITY AWARENESS AND RESPONSE

A survey of housing facilities in the community and personal interviews with community residents, indicated that the community was indifferent toward the mentally ill elderly and that housing opportunities for them were very limited. In some cases, facility managers flatly refused to accept ex-patients.

It was apparent that community awareness had to be nurtured. Newspaper articles publicized the problem and made appeals for aid. The project director made speeches to civic groups and met with as many prospective landlords as possible, most of whom ran homes for the aged. However, such homes were too costly and had an average waiting list of 18 months.

When there was little or no response to this approach, Operation Friendship Project Older Americans ran advertisements in Detroit's two leading newspapers, worded as follows: "Wanted, room and board for elderly people" and "Wanted, one and two bedroom apartments for older people."

---

[20] In three years, Operation Friendship Project Older American helped place one hundred three older people discharged from the milieu therapy ward at Ypsilanti State Hospital. Although aware of the housing needs for a vast number of discharged patients, the project's main concern centered around the 103 elderly patients who would be placed in cooperation with the Ypsilanti Project. (79 persons were placed in the Detroit area and the remaining 24 were helped to find living arrangements in outlying areas.)

Approximately 110 telephone responses were received. The 42 respondents balked when they were told the older persons were former mental patients. The others were evaluated by the project staff for placement possibilities.

Operation Friendship members offered help, too: relatives or friends were willing to take an ex-patient (sometimes more) into their homes. One member's landlord was willing to accept the patients as tenants in her apartment building.

After complete evaluation of existing facilities, the placement program was ready to begin.

During the three years, 79 patients were placed in the Detroit area from the Milieu Therapy Project. An additional ten older persons with histories of mental illness who were already in the community—were given better placements, through Operation Friendship.

Seventy percent of all placements were made in the Detroit area and included such living arrangements as:[21] room and board homes, small group homes, large group homes, private apartments, nursing homes and the homes of relatives.

Of the 79 placements from the hospital, eighteen went to room and board homes, twelve to small group homes, eight to large group homes, twenty-one to nursing homes, eleven to their own families and nine to independent apartment living. The ten persons who were already in the community and received improved placements, included five who went to independent apartments from large and small group homes, one from an apartment to a small group home, and four from large group homes to small group homes.

PLACEMENT RESULTS—AND SOME PROBLEMS

Placement results have been encouraging, but not without problems.

Room and Board Homes.—Of the 18 persons placed in room and board situations, 15 were still in these homes in December, 1969. Three moved to other room and board homes because of conflicts with the original home sponsors. At one home the patient was told to go to bed at 7 o'clock in the evening. In another, the patient was not allowed to smoke and the third person requested a move so that she could take a job caring for an older person with a live-in arrangement. One of the three patients no longer in the community died of cancer following a short period of hospitalization after having been released for a year. His adjustment had been good. The other two patients were returned to the hospital for further treatment.

The patient who functioned best in the room and board home was one who was self-sufficient and independent.[22] Ideally, these persons come to feel they are part of the family, share household duties to some degree, and take part in whatever the family might do as part of their general living routine. For example, the patient is welcome to participate in any recreational activities, such as movies, picnics, parties with the family, or to spend the day shopping with a family member.

---

[21] A room and board home is defined as one that cares for less than four persons; a small group home is one that cares for more than four persons but less than ten persons; and a large group home is one that cares for fewer than one hundred persons.

[22] The warmth and friendliness of managers of these homes is crucial to the continued well-being of the patients. According to the project director of the Milieu Therapy Program at Ypsilanti, "It doesn't do any good to be self-sufficient or independent if the home manager treats you as an invalid, or as an object from whom he's getting an income."

Room and board home placements are easily obtained but not always satisfactory. However, in those homes that *were able to meet the patient's needs and provided the warmth and kindness of a family situation*, the patient adjusted well to the community.

In these homes the sponsors usually worked or had suitable pensions, were active in the community and had some previous contact with the mentally ill, either through work experience, friends, or relatives. A great number were widows who were alone and some were married couples whose children had grown and left the home.

Small Group Homes.—Ten of the twelve patients who were placed in small group homes have remained in the community. The Patients have functioned with varying degrees of success and most of them have continued to use the Operation Friendship program, to help adjust to the Community.

The patient who is most successful in this type of setting is one who is relatively self-sufficient and yet apprehensive about decisionmaking. The friendly support provided by his peers in a small group home is very helpful to him at these times.

However, certain differences must be considered in this type of placement.

Unlike the operation of room and board situations, management of small group homes is a full time job for at least one of the family members, and because the patients placed in such homes need more support than those who go into room and board situations, the sponsor should have some prior experience in patient care. Another consideration is location. Although many of the patients who were placed in small group homes traveled great distances to participate in the Operation Friendship programs, a greater degree of success could be realized if there were such programs located in areas where there are heavy concentrations of this type of facility. The Project has found that the patients who make use of Operation Friendship's social programs for a period of time after release from the hospital, make a far superior adjustment to the community than those who do not. Indeed, greater use of Operation Friendship seems to be an indication of the patient's potential for future success.

Large Group Homes.—Eight persons were placed in large group homes. One was returned to the hospital for further treatment and two were moved to other placements within the community as they were making poor adjustments.

These homes are essential to a particular group of former patients. Those who are well enough to leave the hospital, and do not need the specialized care of a nursing home; yet cannot meet the challenges of the outside world without the security provided by large numbers of peers and the anonymity offered in such a facility.

Again, the proprietor of the large group home must have had experience in caring for the mentally ill, and it is preferred that there be some kind of activity program in this type of arrangement. Unfortunately, this is usually not the case. Many of these places take on the characteristics of a back ward at the hospital. They do not often give the former patient the opportunity to grow emotionally or to use the skills he has learned in the hospital.

Although the project has remained in touch with the patients so placed, none of them have become involved with the Operation Friendship social programs.

These patients had a somewhat longer period of hospitalization than the general placement group (average stay—19 years). The Operation Friendship Older American Project found that these long-term, chronically institutionalized patients could remain in the community in the large group home setting, but were not likely to advance unless there were specialized programs developed for them within the home or in the immediate community.

Private Apartments.—Six of the nine persons placed in private apartments have remained in such placements. Two were moved to small group homes and one was returned to the hospital for further treatment.

In spite of the small number of persons successful in this living arrangement, project personnel have been encouraged by their level of competence and independence in the community. An interesting development occurred at Operation Friendship lounge because of the project's efforts in this area. A number of other "members" realized that they also could live independently. As a result, five of these persons were helped to establish apartments, and still another group of five were given placements that required a higher degree of social competence (i.e., from small group homes to family homes, etc.).

The patients placed in apartments directly from the hospital were very self-sufficient and usually had held some position of leadership on the milieu therapy ward—such as ward payroll clerk, manager of ward store, the ward social planner—and were among the ward's best workers.

The apartment-dwelling patients, including those who were "members" of Operation Friendship, made their own friends and social contacts in the community. Soon, they stopped coming to the lounge, although some still drop by from time to time.

Still, problems arise. First, (as has been mentioned earlier) was finding a suitable apartment within the income of the patient, since most of these persons were supported by Social Security, Old Age Assistance or Aid to the Disabled—and had the added burden of not having their citizenship rights restored. Other problems involved making arrangements for rent deposits when the patient is totally without funds and obtaining inexpensive, attractive furniture. Both problems were eventually solved through donations from the Volunteer Council and interested parties in the outside community.

Family Placement.—Ten of the eleven persons who went to live with families or relatives have remained with them. The remaining patient died within less than a year of release.

Although these former patients had made good use of the Operation Friendship activities while they were still in the hospital, few were able to continue after their release because of transportation problems. Only one, who lives nearby, has attended consistently; and he has made an excellent adjustment. Some of the other patients call occasionally and are visited by volunteers, and generally are doing quite well.

However, the project feels that they would make use of the Operation Friendship Lounge if distance and physical handicaps did not deter them.

Nursing Homes.—All of the twenty-one patients who were placed in Nursing Homes have remained in such facilities. In most instances their placement represents continued institutionalization as the

nursing homes are not as therapeutic as the hospital had been and the patients seem generally unhappy.[23]

LOOKING BACK—SOME RECOMMENDATIONS FOR THE FUTURE

Average age of the patients placed by the Operation Friendship Older American Project was sixty-two and five months, and the average term of hospitalization was 17 years. These former patients were men and women from varied racial and ethnic backgrounds.

Seventy-two of the seventy-nine patients placed in the community through the project have remained. Two of the seven who are no longer in the community died, and the others were returned to the hospital for further treatment.

It is clear, then, that there is considerable merit in this type of cooperation between the community and the hospital.

Of course, an integral part of any such cooperative planning program is the total involvement of the community agency in its follow-up efforts—both before and after release from the hospital.

Thus, before placing this group of older patients in the community, Operation Friendship had to give consideration to several factors:

—The patients' level of functioning on the milieu therapy ward as interpreted by the University and hospital staffs.

—The practicality of the hospital's request for placement in view of what was known of the community and its resources, as well as the patient's motivation and financial circumstances.

—The patient's physical health and his ability (or inability) to handle whatever medication he might be receiving.

—The patient's ability to make use of the Operation Friendship Lounge as a social tool to improve his level of performance while still in the hospital and after his release.

In other words, each patient was dealt with as an individual with separate needs, wants, and abilities, and not as a part of a "mentally ill group."

After placement, the patients were visited by the Operation Friendship volunteers, and were encouraged to attend the many activities at the center. Those persons who could not attend because of transportation problems, physical disabilities, etc., were visited and telephoned in their new homes.

It is important to remember that the mental patients we have been discussing had been hospitalized for at least 12, and as long as 19 years. Most of these persons have lost family and social ties in the community. The shock of returning to the outside world—a society vastly changed from the one they left—can be overwhelming,[24] and

[23] Some nursing homes have introduced excellent therapeutic programs and recreational activities. However, they are not to be found in this community. For example, the patients are not locked on the milieu therapy wards at Ypsilanti but when they are released to the nursing homes in the area they find locked doors. Furthermore, at Ypsilanti the patients are encouraged to care for themselves, make their beds, and to be as self-sufficient as possible. When released to the nursing home they find that they are not allowed to do much for themselves, eventually losing the emotional strength and self-reliance they gained in the hospital.

[24] For example, Operation Friendship found a home for an 83-year-old patient from Ypsilanti's milieu therapy wards, but the gentleman wanted to return to his old neighborhood which had been converted to an urban renewal project. He could not accept the changes he found there and tried repeatedly to find his old friends. For some time he refused to leave the hospital, but through attendance at the Operation Friendship social programs, he became more comfortable in the community and was finally placed in a satisfactory living arrangement. Another example of the difficulties facing elderly patients who have spent many years in mental hospitals was provided by Miss Susan Rourke, Director of the Operation Friendship Older Americans Outreach Project. The Project placed a 61-year-old woman, who had spent 30 years in a mental hospital, in an apartment. At first, she was in constant contact with the Project, asking such questions as how to store leftover food, and whether it is acceptable to launder towels with other clothing. These simple tasks were confusing and frightening to a woman who had been denied the need to make such decisions for 30 years. However, this patient soon adjusted to independent living. She now has a savings account—from the money she receives on welfare—and is a volunteer at a nearby nursing home.

is considerably softened by a supportive community agency such as Operation Friendship.

A social agency such as this one, with its communication with the hospital and other referral agents, and comprehensive social and therapeutic activities, offers its members the invaluable opportunity to establish satisfying relationships with others and to gain emotional support.

The staff at Operation Friendship is concerned (as is the staff of the Ypsilanti Project) about the plight of patients who come from such hospital rehabilitation programs and, once in the community, do not have the opportunity to continue developing the skills they have learned.

Some solutions to these problems may be forthcoming from "Operation Older Americans:" "Community Services to the Aged Mentally Ill," a three-year demonstration project now in its second year at Operation Friendship.[25]

The program has two major goals. To reach and serve those post-hospitalized elderly persons (or potential hospital patients) who have been unable to use the services of Operation Friendship; and to train sponsors and managers of boarding and group homes in the development of therapeutic activities to enhance the quality of life within these facilities.

The Project has placed graduate social work students in selected large group homes to work with residents and home sponsors. Additional training opportunities are provided to sponsors and employees of the facilities through workshops and seminars conducted in several "branch Operation Friendships" which have been established (as part of the demonstration project) in local churches in the area. The "branch offices" also serve as outreach posts which make many of the services of Operation Friendship available to those "members" who reside some distance from the main Operation Friendship site, as well as to those elderly persons in the community who wish to—and need to—become "members" of this supportive organization. According to the Project Director, "We see the establishment of local "branch 'offices' as the direction in which we want to move, so our services can be closely available to our members, an especially important factor when the mobility of the aged is assessed." [26]

With the addition of the "Older Americans Project," [27] Operation Friendship has become almost a full-service agency (lacking only inpatient care), intended to bring hope and the possibility of a full and satisfying future life to hundreds of former and potential elderly mental patients in the Detroit area.

---

[25] Funded through Title III Older Americans Act grant from the Michigan Commission on Aging, and sponsored by the Detroit Section, National Council of Jewish Women.

[26] In written communication with Miss Susan Rourke, MSW, Project Director, Operation Friendship, January 8, 1971.

[27] Operation Friendship intends to continue the Community Services Project (Project Older Americans) after termination of the Title III Older Americans Act grant through: support from the Detroit-Wayne County Community Mental Health Services Board; development of financial responsibility by existing community resources such as the Detroit Department of Parks and Recreation, the YMCA, YWCA, United Community Services, and a number of "grass roots" organizations in the area; and through promotion of programs which involve certain aspects of the Project within groups or organizations not currently addressing themselves to these mental health problems. The feasibility of developing a corporate structure is being investigated, which would allow small contributions from organizations and individuals, to permit continuous growth and expansion of services at Operation Friendship.

Elderly mental patients will be forever institutionalized if boarding homes, nursing homes and related facilities, are not encouraged to develop programs that are dedicated to social and emotional growth as well as physical care.

Such programs would not only provide for continued treatment for these people—who no longer need to be in a hospital—but would also offer those persons in the community who might be potential candidates for hospitalization an opportunity to become more involved and thereby, avoid institutionalization.

PROJECT STUDY TWO

NORTH CAROLINA STATE HOSPITALS AND SATELLITES: A STATEWIDE MOBILIZATION OF RESOURCES

> . . . we have helped place out of State hospitals persons who have been institutionalized from two to 45 years. Some of our most successful cases have been those where men and women were in our state institutions for 30 and 40 years. We have been able to make plans not only for the fully ambulatory patient who could be returned to group living in the community but also for the totally bedridden. We have planned for those who were apparently mentally competent on release and for those who were very confused and would need close supervision.—Speech by Ellen Winston, then Commissioner, North Carolina State Board of Public Welfare, September 16, 1957.

The program to which Commissioner Winston referred in 1957 was then already more than a decade old.

And, in the dozen years since, it has been refined and broadened. For those committed to any one of the four state mental hospitals in North Carolina, the hope of return to the community is now more justified than ever before.

The North Carolina achievement is remarkable because—in a state of 100 counties, extending approximately 500 miles from the east at Cape Hatteras to a westernmost boundary in the Great Smokies—distance and dispersal of services can cause formidable problems. And yet, the State Department of Public Welfare and the State Department of Mental Health have joined forces with hundreds of private and public resources to help individuals find their way out of the institution to the most appropriate and economical level of care or shelter.

A statewide mobilization of manpower, facilities, and ideas is yielding important dividends in every county of North Carolina.

INNOVATIONS:

1. SPECIALISTS TO THE AGING, LOCATED IN EACH OF THE 100 COUNTIES OF NORTH CAROLINA.
2. MEDICAL, MENTAL HEALTH CARE AND REHABILITATIVE SERVICES AVAILABLE TO ALL PERSONS RESIDING IN LICENSED GROUP CARE DOMICILIARY FACILITIES FOR THE AGED.
3. IN-SERVICE PSYCHIATRIC TRAINING SESSIONS, PROVIDED BY STATE FUNDS, FOR PERSONS WORKING WITH THE AGED.
4. UTILIZATION OF DEPARTMENT OF PUBLIC WELFARE, SECTION ON PSYCHOLOGICAL SERVICES TO STATEWIDE PROGRAM OF SERVICES TO AGING.

BACKGROUND: THE BEGINNINGS OF A STATE PROGRAM

It is generally agreed that institutionalization is not the only answer for a great many aged mentally impaired persons in need of help and care. Day treatment centers, night hospitals [1], centers for diagnoses and temporary treatment of acute reversible conditions, community health and mental health centers, screening programs, health education and referral services, home nursing programs, homemaker services, social and recreational services, rehabilitation programs, home-delivered meals, volunteer friendly visitor services; all could serve as answers to unnecessary and costly institutionalization of older persons.

However, such programs are usually fragmented under jurisdiction of Federal, State and local authorities, and serve only handfuls of individuals when a far greater need exists.

The North Carolina program is unique because at the very beginning (1947), the State Department Social Services joined forces with the State Department of Mental Health to implement a placement program for discharged elderly mental patients who needed custodial care. The two departments worked closely with county agencies, religious groups and charitable organizations to provide not only placement, but also to develop community awareness and acceptance of the former mental patient.

The beginnings of the partnership were modest. The Services to the Aging Section of the Department of Public Welfare licensed and inspected group care facilities for the aged [2] (the State legislature had voted in 1945 to require such licensing) and initially worked with one of the four State mental hospitals (John Umstead Hospital, in Butner, North Carolina), on the Release Planning Service, a pilot project designed to return a limited number of elderly patients to the community. At first, there was a need to select only those patients who proved to be, through performance, study and observation, individuals who could *surely* function outside the hospital, both for the sake of the patient and for good community relations.

By 1954, the program was serving all four State Hospitals and had placed over 500 patients, either with relatives or in carefully selected group care facilities.[3]

Consequently, State funds were appropriated that year to supplement public assistance for licensed boarding home placements. This financial backing served as a recruitment tool for expanded facilities, as it further emphasized the varieties of need for accommodations and personal service.

At that time there were four Specialists to the Aging within the Department of Public Welfare. They traveled throughout the State, working with licensed group care facilities to enhance their understanding of the mental patients' needs, and with the State hospitals to provide the best and most comfortable placement possible for the elderly patients.

---

[1] See Glossary p. 183, for description of night hospital.

[2] Group Care Facilities for the Aged, include: Personal Care Homes With Skilled Nursing (provides some skilled nursing care, in addition to its primary domiciliary or personal care function); Personal Care Home without skilled nursing; Sheltered Home (provides room and board and minimum services to those aged persons who can essentially manage their own care and affairs).

[3] Of the 500 released patients provided for through the efforts of the State Board of Public Welfare, the State Department of Mental Hygiene, and county welfare departments, approximately 50% were placed in boarding homes and 50% in homes of relatives.

It should be noted that the patients who were being released had been institutionalized from *two to forty-five years,* and the greatest number of discharged patients had been in the hospital the longest period of time. The long period of institutionalization had meant loss of family ties for many.

It was found that a substitute family relationship was often most successful with this group of patients. Every effort was made to find and to develop appropriate small group homes (those caring for fewer than 10 persons) or foster care homes (a single adult or a couple care for one or two persons).

The requirements of the small homes were that they provide a family setting: a living room and a pleasant dining room with a minimum of the atmosphere and structural picture associated with institutions. Emphasis was on returning the patients to their old communities if at all possible, so that they could maintain life-long ties with relatives and friends, and with community institutions such as church, schools and library.[4]

The State agencies recognized that if individuals could not be returned to their own homes, the next best place for them was a good substitute home. In fact, this awareness was the basis of the original group care licensing legislation in the State in 1945.[5]

ORGANIZATION OF SERVICES TO PROVIDE COMPREHENSIVE CARE[6]

Originally, the major function of the Services to the Aging Section of the State Department of Social Services, was to license and inspect group care facilities for the aged (with additional services mentioned earlier). Due to the population growth among older persons in the State and the expansion of the Release Planning Project, the State Board of Public Welfare voted on August 12, 1955, that in every county where a licensed group care facility existed, there would be a person designated as Specialist on Aging, who would be responsible for the supervision of those facilities offering services to the aging and disabled. Today, there are Specialists to the Aging working in all of the 100 counties of North Carolina.

The role of the County Specialist to the Aging is varied. His primary function is to supervise and work with operators of group care facilities located in his county. He also works directly with families and individuals in preparing and/or evaluating the possibility of the persons entering such facilities (either from the State Hospital or from the person's home) and with the operators in an effort to meet the individual needs appropriate to each resident.

---

[4] Abstracted from "Reducing the Number of Patients in Mental Hospitals by Providing non-Institutional Care for the Aging"—by Ellen Winston, (then) Commissioner, North Carolina State Board of Public Welfare, in a speech before the National Association of State Budget Officers, 1957.

[5] Abstracted from above remarks.

[6] The Committee is grateful to Mr. Braxton Warner, Chief, Section on Services to the Aging, North Carolina Department of Public Welfare until late 1970, for the information regarding North Carolina's programs for mentally ill aged—found on this and the following pages of this Report.

Mrs. Annie May Pemberton, one of the originators of the North Carolina Program, has also provided the Committee with valuable information for this chapter. Mrs. Pemberton served as Chief, Section on Services to the Aging, Department of Public Welfare from the inception of the licensing program until Jan. 1, 1970.

In large metropolitan areas, there may be more than one Specialist to the Aging. Each concentrates on a specific function, such as casework or supervision of facilities. In the smaller communities, the Specialist carries a dual role. He not only supervises facilities, but acts as caseworker and also may be called upon to help develop services where there are none.

At the State level, the Department of Public Welfare has five Consultants, one Supervisor and a Chief in the Department of Public Welfare's Section on Services to the Aging. The Consultants are assigned to the territories that are service areas of the four State Hospitals, and they are actively involved in working with the counties in the development of homemaker services, attendant care programs, and when appropriate, the use of personal representatives and guardians for those persons who are not responsible for their own affairs.

As was discussed earlier, the Department of Social Services, Section of Services to the Aging, in partnership with the State Department of Mental Health, helps make arrangements for elderly patients recommended for discharge from State Hospitals, to return to the community. The County Departments of Public Welfare caseworkers work directly with the patient and his family.

When arrangements cannot be made for a return to the family (for financial or emotional reasons; or because of loss of family in the case of many of the aged patients), plans are made directly with the patient—on a one-to-one basis—to locate a facility to best meet his particular needs.

WHEN THE "CURRENT" STATE HOSPITAL PATIENT BECOMES A "FORMER" PATIENT

From July 1, 1966, through June 30, 1968, more than 1,325 patients were placed through local departments of Public Welfare into the community, from the four State Hospitals for the Mentally Ill in North Carolina.

Since the Section on Services to the Aging has the responsibility of placing *all* adults referred from State Hospitals, exact statistics according to age are not available. However, the Chief of the Section on Services to the Aging estimates that, of those patients returned to the community in the two year period, more than 500 were 65 and over.[7]

Group Care Facilities.—The majority of placements were made in licensed group care facilities. At the present time, 766 such homes (with a bed capacity of 9,316) are operating in North Carolina.[8] The group care homes provide domiciliary care with such nursing or personal care as individuals could receive in their own homes were relatives or other persons (paid or unpaid) available to provide such care. Nursing Homes are not included here, as the nursing home is usually a medically oriented facility to provide skilled nursing care and which is under the licensing authority of another State agency.[9]

---

[7] Reports from the State Hospitals show that the patients placed through this program had approximately a 10% rate of return to the hospital. Before the program was introduced, the rate of return was 50%.

[8] Mr. John Syria, the present chief, Services to the Aging Section, North Carolina Department of Social Services, provided the Committee with figures, from information compiled as of November 30, 1970.

[9] Some patients have been placed in skilled nursing care homes.

Medical care services available to the residents of licensed group care facilities include the following:

1. Required annual physical examinations for all residents of licensed group care facilities, and those patients released to their own homes.
2. County Health Clinic Visits for residents of group care facilities. Resident is usually accompanied to the Clinic by the sponsor of the home, or a caseworker.
3. Administering of medication (only in those homes which are designated "Personal Care Home with Skilled Nursing").
4. Required annual chest examinations and X-rays for all residents of licensed group care facilities.
5. Visiting County Health Nurses services, when indicated by physical examination, or state hospital records.
6. Out-patient care with local State Hospital, for those patients who still require psychiatric treatment.
7. Mental Health Clinic Visits (regional basis) when indicated by State Hospital Records, Social service referrals, or behavirol problems which may arise after release from the Hospital.

North Carolina has fifty-one mental health clinics throughout the State's 100 counties, and each of the four State Hospitals provides outpatient services. This wide distribution of services provides for continued treatment to all released mental patients (whether they reside in group care facilities or in their own homes), as well as to those persons who might be "potential" patients.

The services listed above are available to *all* adult patients released from State hospitals, whether they reside in group care facilities, with relatives, or independently, in their own homes.

Rehabilitative Services.—Additional rehabilitative services are available to the elderly patients, although they vary with the resources at the local level. The existing services include: leisure time activities, volunteer friendly visitors, vocational rehabilitation, group work, adult education and sheltered workshops. Rehabilitative services are available to residents of group care facilities and those persons living independently.

The North Carolina program changes, to meet change. Thus, the County Supervisors to the Aging are continuously working to develop rehabilitative services in their counties, for persons released from State Hospitals, and they also provide preventive services for those who may be "potential" patients in such institutions.

Nursing Homes.—For patients who need professional nursing service placement is made in a skilled nursing home or combined home (where both types of service are available). The North Carolina State Board of Health licenses skilled nursing care homes, and there are 114 such facilities in the State.

In a letter to Senator Harrison Williams,[10] Mrs. Annie May Pemberton[11] described a very real problem concerning the placement of former mental patients in skilled nursing homes and related facilities.

> **Homes for the Aged and Nursing Homes operated by concerned persons are pressured into accepting residents or patients simply for lack of alternate services. Due to insuffi-**

[10] Former Chairman, U.S. Senate Special Committee on Aging.
[11] See footnote 6, p. 53.

cient money and energy to re-establish himself in the community following such expedient admissions, results in continued unnecessary and expensive long-term care and abuse of a specialized community resource.

Even in a State that is working hard to mobilize a coordinated system of resources for elderly former mental patients, problems such as these arise to form barriers to full utilization of those resources.

REFINEMENTS: SPECIALIST SERVICES AND SHARPENING COMMUNITY AWARENESS

At John Umstead Hospital, eleven years after the program was introduced, the Service became a non-medically oriented unit known as Convalescent House. Patients ready for release are referred here before attempting to live independently in their own home towns. At Convalescent House, the hospital staff, patients and professionals from community agencies, can look together at the anxieties involved with discharge and determine which ones are psychiatric in nature and which ones have to do with realistic differences between independent living and institutionalization. This procedure has proved to be an important aid in bridging the gap between the hospital and the community, especially for those patients who have been hospitalized the longest.

While Convalescent House was being established the two State agencies began to re-evaluate the placement program, and exploring those areas needing further development.

HOSPITAL SPONSORED WORKSHOPS

Although the Release Planning Service had successfully discharged large numbers of elderly patients into the community, the lack of community understanding and responsibility for the released patients was still a fundamental deterrent in returning older individuals to the outside world.

For example, a number of licensed group-care homes and homes for the aged had accepted the responsibility for caring for former mental patients, but none of the administrators or sponsors were trained or experienced to provide the sort of supervision and guidance which could offer continued growth in the community.

The State Department of Social Services and the Social Work Department of the John Umstead Hospital agreed to sponsor an all-day workshop at the hospital, inviting professionals from the community and administrators of group-care homes and homes for the aged. The workshop was held on May 12, 1964. It was so well attended and audience reaction so encouraging that the workshop was repeated twice, to cover all regions of the State. The final workshop series was introduced October 1966.

The success of the hospital workshops created an awareness of the value of in-service training programs to professional workers and sponsors of group-care homes. However, the caseworkers in the Section on Aging did not have access to any such training program, needed to provide deeper understanding of the psychology of aging.

GEROPSYCHIATRY TRAINING PROJECT

The State agencies decided to enlist the aid of the Duke University Medical Center's Geropsychiatry Training Program. After a series of planning conferences with the Director of the Section on Aging, the Director of staff training of the Department of Public Welfare and members of the Geropsychiatry Training Program, a two-year training program was initiated, supported by a grant from the North Carolina Fund.

The primary goals of the training program were to:

1. broaden the caseworkers' knowledge of biological and psychological changes inherent in the aging process, as well as sociocultural influences;
2. increase comprehension of the multi-faceted problems of specific individual cases through a case consultation method;
3. enhance the effectiveness of the client-caseworker relationship as a supportive tool and to increase the caseworker's familiarity with some appropriate therapeutic techniques;
4. increase the worker's skill in recognizing mental disorder and in making appropriate referrals to the psychiatrist, thus enabling the caseworkers to function more effectively as a screening agent and a first line of defense in the community.[12]

The Geropsychiatry Consultation Project was carried to the counties by dividing the workshops up into eight geographic areas for presentation of instruction, audio visual material, and case discussion.

Participants were Specialists to the Aging, regular caseworkers, Directors, Supervisors, field representatives psychologists, Services to the Aging staff, Duke University staff, and visitors. The participation of other professionals such as public health nurses, social workers, mental health clinic and state hospital personnel was encouraged and the results were gratifying. It was found that such participation by other agency personnel helped interagency communication and collaboration.

Attendance at the training sessions was influenced by conflicting meetings in other parts of the state, busy work schedules, and weather conditions in the mountainous areas of the state. Many participants had to drive 100 miles or more to attend the sessions. Therefore, the 2,500 total participation was gratifying. During the first year of the program, there was a steady rise in attendance, from a total of 140 participants at the first session to a total of 295 at the sixth session. The State Department of Welfare feels that individuals attending the training sessions gained a great deal of knowledge which helped enhance their skills in working with those aged persons who were (or who might become) mentally ill.

Many requests have been received by the State Department of Social Services, from county welfare departments for more of the same and similar kinds of consultation training sessions. The State agency has requested funds to carry on related consultations and training projects. This request has been approved by the State Legislature.

---

[12] Abstracted from: James Elmore, M.D. and Adriaan Verwoerdt, M.D.—"Geropsychiatric Training for Caseworkers"—*The Gerontologist*, Vol. 8, No. 4, Winter, 1968.

69-261 O - 71 - 5

SECTION ON PSYCHOLOGICAL SERVICES

Each county in North Carolina now offers psychological consultation to the Division on Services to the Aging. The Section on Psychological Services is another section within the Division of Social Services in the State Department of Public Welfare. The county caseworkers find the consultations an invaluable aid in determining when psychological services might be helpful in improving the functioning of an aging individual, and a preventive measure in offering older persons alternatives to hospitalization.

The Phychological Services Section consists of a Chief and approximately 16 psychologists. They bring diagnostic and consultation services to each county department of public welfare throughout the state. These services are not limited to the aging, or to public welfare recipients, but are offered to any person, child or adult, of any age, race or financial status who is referred for this service. Psychological Services are in the form of clinics and they provide *individual* psychological evaluations, as well as personality and vocational appraisals.

TITLE XIX VENDOR PAYMENTS

On January 1, 1970, North Carolina became one of the remaining seven States to go into title XIX (Medicaid). Under this title, vendor payments are made to State Hospitals for the metally ill for services to be offered to former and potential elderly patients (aged 65 and over) of State hospitals in the outside community.

Each person requesting and needing services must be visited at least once a month by a caseworker unless there is some reason the particular individual does not require such frequent visits. Services include: appointment of a personal representative or guardian, homemaker services, the use of attendant care in the patient's home, use of vocational rehabilitation, public health services, as well as other related agencies who may aid the functioning of the patient.

Since the State only recently entered this program, it has not yet developed a service delivery system. The State Department of Public Welfare and the State Department of Mental Health are looking forward to a full and constructive utilization of the program, so that this often neglected group of citizens will have some guarantee of treatment and services which have been long overdue.

HOMEMAKER SERVICES

Homemakers, sometimes called home aides or home health aides, offer a genuine and much needed service to many older persons who are chronically ill, either mentally and/or physically. And, for the older individual who resides in a rural community, often miles away from the nearest city, the homemaker provides sometimes the only means for remaining at home, and continuing in an independent living arrangement.

At this time there are only 40 homemakers who can work with adults in 27 of North Carolina's 100 counties.[13]

---

[13] Social Services Aides are being trained to assist the Homemakers. Some of their duties include, running errands, and providing transportation for elderly recipents of Homemaker care. At the present time, there are only five such positions filled in the State.

The former Chief, Section on Services to the Aging, explained the slow pace this way: [14]

"It is difficult to expand a homemaker program for the elderly when Federal Matching is unbalanced, as it is in this situation. For those homemakers that work with adult cases either 36% or 50% of the salaries are matchable by the Federal Government, where for those who work with AFDC and Child Welfare, a 100% down to 65% is matchable. This is a vital and needed service for so many of our elderly people. It is the homemaker that can play an important role in helping an elderly couple or individual maintain their home while going through a crisis situation. It is the homemaker that can help them in learning how to cook from a wheelchair or how to shop for groceries more economically or offer support of various types to one member of the family while another is recuperating from an illness. It is these types of services that so often prevent the home from breaking up and help a person maintain his optimal level of functioning."

RURAL AREAS—THE GREAT CHALLENGE

Many of North Carolina's 100 counties are very isolated rural areas. Along with the services mentioned earlier, the State has developed smaller, family care homes (licensed for the care of five or less residents) and homes for the aged in most of these areas. Homemaker services are being developed in an effort to reach out to those elderly persons who are able to maintain a level of independence. More mental health clinics are being established in these areas to provide psychiatric services to this group of North Carolina's aging population. The use of volunteers and sub-professionals is being developed to help those mentally ill aged persons living in rural areas take advantage of the resources which are not located near their homes and to provide friendly visiting services for those who need someone to visit with them on a regular basis.

Because of the remoteness of most rural communities, older individuals who might be physically and/or mentally ill are frequently neglected. Transportation systems in such areas are inadequate, and the nearest clinic may be miles away from the person's home, as well as the closest neighbor or a friend. The shortage of private physicians residing in rural communities has reached crisis proportions and quite often there is no such professional for an elderly person to call upon for help. The rural elderly make up the largest number of rural poor and in many cases, are without telephones, and automobiles. Thus, there is no way of communicating to anyone that they are ill and need help. If such individuals live alone, the most minor accident may mean disaster.

> CASE STUDY: Mrs. X is widowed and lives alone, 40 miles from the nearest town. She has no telephone and no means of transportation. She falls, precipitating a stroke, which results in a mental disorder. She becomes frightened and disoriented, and soon finds she cannot perform the simplest chores for herself, such as housecleaning or cooking. If Mrs. X is fortunate enough to have a neighbor or friend stop by from time to time to visit, days or weeks may pass before help comes. Visits from friends are

[14] Mr. Braxton Warner, cited in footnote 6. The present chief, Section on Services to the Aging in spoken communication with the Committee, concerned with this assessment of the homemaker problem.

few and far between. Thus, when help finally arrives, the time for prevention is long past, and Mrs. X may be hospitalized for the rest of her days.

This is a hypothetical case. But the Committee has heard testimony which provided ample evidence for such a case.

RESULTS AND SIGNIFICANCE

The results of such a program cannot be measured in terms of numbers of persons "cured" or "rehabilitated," as it might for younger persons, just as a recitation of statistics relating to the numbers of individuals discharged from State hospitals is not necessarily an indication of success in dealing with the problem of mental illness among the elderly.

When a person becomes mentally ill in old age the mental disorder is usually accompanied by physical illness. An elderly individual who has grown old in a mental institution quite often has some physical disability by the time he is discharged to the so-called "community."

The urgent need for a coordinated system of services for the elderly—medical, psychological, social, and financial—has been documented in this Report and elsewhere. A system is needed which would work for all older people, not just for those who are already mentally and/or physically impaired, but also for the "well" aged, so they may continue to live independently and with dignity.

In order to be most effective and to reach the greatest number of persons in need, such a system of services should have a central base of operations, perhaps, as in the case of North Carolina, State government.

Unfortunately, local and state governments often leave to each other the problems involved in providing adequate care for the elderly; social welfare agencies turn to health agencies to solve problems; and medical units respond with cries of helplessness in the face of complex personal-family-community problems.[15]

The North Carolina program is worthy of study for a number of reasons:

1. **It began with a clear legal base (state legislation), with a precise definition of purpose.**
2. **The necessary professional staff was available to recruit, interpret and train both the welfare workers and operators (licensed care facilities) engaged in the program.**
3. **The professional staff was able to work with other public and private agencies at the state and local levels, to solicit their interest in the *total needs* of the elderly population.**
4. **The program reaches outward to the general community (statewide) and maintains viable links on all levels from individuals to families and community, and institutionally to the broad array of public and private programs available to the older person in the state.**
5. **A readiness to change in response to the changing needs of the aging population, is an inherent part of the program concept.**

---

[15] Abstracted from: Alvin I. Goldfarb, M.D. "An Exploration of Research Findings"—Research Utilization in Aging, U.S. Department of Health, Education, and Welfare, Public Health Service, No. 1211, 1964.

Thus, the North Carolina Department of Social Services, Section on Services to the Aging, plays both a preventive and a supportive role in caring for mentally and/or physically impaired elderly individuals residing in that State.

The joint effort of two State agencies, working closely with county agencies, State hospitals, and countless other social resources at their disposal, is a viable approach toward a workable solution to the problem of mental illness among the elderly.

This statewide mobilization of resources could possibly serve as a model for other state programs to older citizens, which (as we have seen in North Carolina), could do much to prevent hospitalization, improve conditions for potential and ex-mental patients in the outside community, and ultimately, improve conditions inside the institution for those who must be hospitalized.

PROJECT STUDY THREE

THE SAN FRANCISCO GERIATRIC SCREENING PROJECT: COMPLEXITIES AND REWARDS OF PREVENTION

San Francisco, rich in natural beauty and fondly remembered by most who visit, nevertheless yields disturbingly abundant evidence of mental illness far above national norms for all ages.

The Bay area also possesses much psychiatric expertise on tap at several institutions, including the renowned Langley-Porter Institute.[1]

It was to this Institute that the State Department of Mental Hygiene turned six years ago to help establish a pilot program intended to screen elderly persons on the brink of commitment to State mental hospitals.

The State agency had good reason for concern.

Geriatric commitments to State hospitals from San Francisco alone numbered almost 500 a year. Reports of needless commitments to state hospitals, led the California State Legislature to decide that it might be better to *prevent* such commitments rather than to *undo* their consequences months or years later. And, in 1963 the Legislature appropriated special funds to the State Department of Mental Hygiene for a geriatric screening project.

Innovators in the Legislature and the California Department of Mental Hygiene hoped that the project would provide *alternatives* to hospitalization and promote the proper care of the elderly outside the institution.

INNOVATIONS:

1. PRE-PETITION SCREENING OF PERSONS OVER 65 YEARS OF AGE WHO ARE THREATENED WITH INVOLUNTARY COMMITMENT.
2. SCREENING IN THE PATIENT'S HOME BY A TEAM PHYSICIAN, PSYCHIATRIST AND SOCIAL WORKER.
3. APPROPRIATE ALTERNATIVES, INCLUDING PLACEMENT TO PROVIDE FOR TOTAL NEEDS OF THE PATIENT.

---

[1] The California State Department of Mental Hygiene, given responsibility by the Legislature for establishing the pilot program, assigned a special Department Unit to develop the program intended to screen elderly persons on the brink of commitment to state mental hospitals.

BACKGROUND: COMMITMENT IN CALIFORNIA

To bring an individual before a judge for observation and a hearing that could result in commitment to a California state hospital, anyone—a neighbor, friend, relative, or landlord—once needed only take out a Petition for Mental Illness and submit it, with his signature, to the appropriate county official.

Once that petition was signed, police were empowered—even without a doctor's statement regarding the mental health of the alleged defendant—to bring the person into a hospital for observation. Most often, that period lasted for 5 days.

This was the situation until 1963, when the California State Legislature began a reform of the procedures. Among the reasons for the revision were:

ONE: There was growing awareness, in California as well as elsewhere,[2] that a substantial number of those endangered by such commitment procedures needed care and supervision, certainly not commitment to a mental hospital.

One California study [3] showed that a common cause of commitment was acute brain syndrome. This disorder is a temporary but *reversible* mental disturbance, usually brought about by malnutrition, decompensated diabetes, decompensated heart disease and other similar diseases.[4] Since it is closely related to physical illness and should, therefore be treated in a general hospital, with continuing care at home or in a protective care facility (nursing home or convalescent home), it is not necessary for such persons to be committed to treatment in a mental hospital. But, they were being so committed.

TWO: Awkward legal procedures of the commitment system in California created intricate problems.

Thousands of persons were routinely detained for a five day "period of observation"; precommitment examiners routinely presumed mental disorder; and examinations were frequently performed on a casual basis. Criteria for commitment were very vague, and alternatives to commitment were rarely considered. Although only nine percent of the persons in State hospitals were considered dangerous, *eighty-three percent had been admitted involuntarily*. And finally, although people

---

[2] Neil Chayet, LL.B., in "Legal Neglect of the Mentally Ill" American Journal of Psychiatry, December, 1968, concluded: "Involuntary hospitalization of the mentally ill is raising crucial questions for law and medicine all over the country." Among his arguments in support of that declaration were the following:

In some other states (Mr. Chayet was discussing Massachusetts primarily) the period of observation is as long as 35 days.

"Under present Massachusetts procedure, *similar to that of many states throughout the country*, a person may be sent for a 35 day period of observation at any time prior to trial . . . he is examined by a physician who, in most cases, has had no formal psychiatric training, who decides whether or not the person is psychotic . . . if the physician decides him to be so, he can state that the man is incompetent for trial or hearing. This allows the individual to be committed indefinitely without further hearing or notice. While under the period of observation, such persons are not able to leave the hospital grounds and take part in out-of-hospital privileges which may prepare them for a return to the community.

[3] Marjorie Fiske Lowenthal, "Lives in Distress," Basic Books, New York City, 1964. Langley-Porter Neuropsychiatric Institute study of 530 elderly patients and how they arrived at the psychiatric screening wards of San Francisco General Hospital during 1959. This was the first in a series of studies by Miss Lowenthal and others of geriatric mental illness conducted at the Institute, which helped pave the way for the Geriatric Screening Project.

[4] Clark, Mary Lou—ACSW—As cited in a paper presented at the First Workshop on Comprehensive services for the Geriatric Mental Patient, Wash., D.C., November 30–December 1, 1967.

were committed for "treatment" the care in the State hospitals was frequently *inadequate and possibly harmful.*[5]

CASE STUDY: In March 1963, Mrs. X, aged 90, was picked up by the police on a Superior Court approved Petition for Mental Illness. Her history was that of a recent fall and dizzy spell, followed by inability to walk or talk. She had the routine five-day "period of observation" on the psychiatric wards of the San Francisco General Hospital; and was then committed to a State hospital, away from family and friends, on a diagnosis of chronic brain syndrome with cerebral vascular accident (stroke). The "period of observation" intensified her emotional disturbance and increased her agitation. This, of course, facilitated the court's decision to order commitment. But in the light of patient-needs, her commitment was inappropriate. Mrs. X was neither dangerous nor harmful. She was sick with an organic brain disease [6] and a resultant brain decompensation with emotional disturbances (i.e., when one deteriorates to the point of not being able to care for himself). "Such decompensation is frequently seen in older persons with chronic brain disease and often leads to inappropriate commitments." [7]

THREE: Chronic problems related to generally poor organization of health services throughout the nation had special impact upon the elderly in California.

State hospitals rarely had preventive services for released patients. Community health clinics had few geriatric specialists. State mental hygiene clinics offered help only for those in need of psychiatric care and for the most part ignored other forms of assistance, including financial aid general health maintenance, and social services.

THE GERIATRIC SCREENING PROJECT BEGINS

Confronted by a commitment problem described by critics as scandalous, the 1963 California Legislature appropriated special funds to the State Department of Mental Hygiene for a pilot geriatric screening program. The Bureau of Social Work in that department selected San Francisco as the site; and the San Francisco Geriatric Screening Project became a reality.

The primary objectives of the screening program were:

1. To reduce the number of inappropriate commitments of aged persons to State mental hospitals. *It was not the intent to prevent commitment for those aged persons who needed to be in a State hospital.*

---

[5] All findings listed above were reported in Bolton, Arthur—"Legislative Initiative in the Mental Health Field"—*State Government*, Summer, 1968.

[6] The description of organic brain disease, as found in A. P. Noyes and I. C. Kolb, *Modern Clinical Psychiatry* may be helpful here: Organic brain disease refers to what is commonly called "senility" or chronic brain syndrome. It is characterized by relatively permanent deficit in the capacity of intellectual functioning with symptoms such as confusion, and impairment of orientation, memory, perception, knowledge and judgment. See Glossary for further descriptions.

Dr. Alvin I. Goldfarb, in writing about these disorders and problems of treatment, has said, "Brain syndrome is the psychiatric term for organic brain disorders, and is a reflection of brain damage. This is a mental illness and needs *medical and psychiatric supervision and protection.*"

[7] In Rypins, Russel F., M.D. & Clark, Mary Lou, ACSW—"A Screening Project for the Geriatric Mentally Ill"—California Medicine—October 1968.

2. To provide alternatives to State hospitalization by developing and utilizing community resources and services that would more adequately meet the needs of this group. This was not to be simply a process of "screening out" of those who did and did not belong in a State hospital.

3. To carry on such other activities as would promote the care of geriatric patients outside of the State hospital, such as, providing consultation and information to persons and agencies responsible for services to this age group.[8]

The Pilot Program Succeeds.—As will be seen later, pre-petition screening yielded many significant findings about mental illness among the elderly and alternatives to commitment. After a 2-month trial, pilot project techniques became the matrix about which a permanent San Francisco Geriatric Screening Project was built.

Another tangible result of the pilot project's pioneering was the passage of legislation which—after July 1, 1969—banned commitment of a Californian to a State hospital for the mentally ill, voluntarily or involuntarily, prior to screening by local mental health programs.[9]

Pertinent paragraphs, abstracted from the Lanterman-Petris-Short Act, expressing philosophy and intent, follow:

To end the inappropriate, indefinite, and involuntary commitment of mentally disordered persons and persons impaired by chronic alcoholism, and to eliminate legal disabilities.

To provide prompt evaluation and treatment of persons with serious mental disorders or impaired by chronic alcoholism.

To guarantee and protect public safety.

To safeguard individual rights through judicial review.

To provide individualized treatment, supervision, and placement services by a conservatorship program for gravely disabled persons.

To encourage the full use of all existing agencies, professional personnel and public funds to accomplish these objectives and to prevent duplication of services and unnecessary expenditures.

To organize and finance community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs.

It is further intended to better utilize existing resources at both the state and local levels in order to improve the effectiveness of necessary mental health services.

To integrate state-operated and community mental health programs into a unified mental health system.

To ensure that all mental health professions be appropriately represented and utilized in such mental health programs.

---

[8] Objectives listed above were reported by Mary Lou Clark, ACSW, Director, Geriatric Screening Project, in a paper presented at First Workshop on Comprehensive Services for the Geriatric Mental Patient—Washington, D.C., November 30–December 1, 1967.

[9] The Lanterman-Petris-Short Act went into effect on July 1, 1969. It is no longer legal for a Californian living in a county of more than 100,000 persons to be admitted to a state hospital for the mentally ill, voluntarily or involuntarily, prior to screening by a local mental health program. The total state population was 19,535,000. Counties over 100,000 represent 18,547,000 persons. Thus, the legislation covers 19,192,000 residents of the state (98.26% of total population). The counties (32) with under 100,000 persons, have the option to, or not to provide a community mental health program as set forth in the legislation. It should be noted that of these 32 counties, 15 presently have such programs.

WHO COMES TO THE SAN FRANCISCO GERIATRIC SCREENING PROJECT?

Screening services are limited to persons 65 years and older, residing in the City and County of San Francisco.

A major group of individuals routinely referred to the Project are those persons for whom a relative, friend, or landlady, requests a Petition for Mental Illness, most often with the idea of commitment in mind. The District Attorney's office refers these individuals directly to the Geriatric Screening Project to determine whether such action is necessary. This procedure was originally suggested to the committing judge, who not only fully endorsed it, but refused to sign orders of detention on aged persons unless they were recommended to the Project.

> **Thus, intervention is possible at the point of admission to the psychiatric ward and not after the patient bears the label of "psychiatric patient." The project staff has observed that persons admitted to the psychiatric observation ward of the County Hospital are much more likely to be committed and it is more difficult to make a community placement from the psychiatric ward.**

The Old Age Assistance units of the local County Public Welfare Department contribute by far the highest number of referrals. Many of these persons have no one, such as a friend, or relative, to act for them in obtaining necessary psychiatric and medical attention.

Other sources of referral come from private physicians, hotel or apartment managers, public health nurses, community social agencies, and other interested parties.

THE SCREENING TEAM IN ACTION—INNOVATIONS

The staff of the San Francisco Geriatric Screening Project comprises a part-time internist and psychiatrist, full-time psychiatric social worker, supervising psychiatric social worker (who functions as coordinator), and a senior stenographer.

Once a referral is received, the Screening Team proceeds as follows:

A social worker obtains a history of the patient from the referring person or agency. Others who have information to contribute are also contacted and interviewed. The patient's private physician (if there is one) is always contacted and informed of the Project's involvement. If the patient has no physician, and is agreeable to being under private care, the project physician will secure a physician for him.

A staff conference follows, to determine which of the two staff medical specialists will be more appropriate to examine the patient. The patient is seen in his own home by the staff psychiatric social worker and physician (internist),[10] and not in an office. The home visits have proved extremely valuable. For example, in a doctor's office a patient can say that he is always careful with cigarettes, he never leaves pots and pans burning on the stove and he always maintains good housekeeping standards. On the other hand, the home

---

[10] A substantial number of home visits are made jointly by the psychiatrist and the internist, along with the psychiatric social worker.

visits make it possible to determine whether all these statements are true. The staff can *see* whether the patient has food in the refrigerator, is careless with cigarettes and matches, and is a satisfactory housekeeper. Such visits leave no doubt as to whether the patient is functioning adequately or not. The actual time spent at a patient's home ranges from ten minutes to well over two hours.

A mentally disturbed aged person often requires more time to assess; perhaps the patient is deaf and the doctor has to repeat questions or, the elderly person might be frightened of strangers and require a great deal of reassurance. The patient may have a serious medical illness requiring immediate hospitalization, but might be fearful of hospitals and what will happen to him when he is admitted. If a family member or friend is present, he requires further interpretation by the social worker of the patient's problems.

Most of the cases screened by the project staff are considered crisis situations and therefore decisions must be made and recommendations implemented without delay. A second home visit for evaluation purposes is an exception.

AFTER THE SCREENING: ALTERNATIVE TO COMMITMENT

The project staff finds that many older patients fare better if they can be cared for in their own homes. In addition they are more content and satisfied if plans are made that enable them to remain there. Of course, such plans must be appropriate to the patient's needs as well as practical and realistic. A priority goal is to maintain the individual in his own home.

Among the community resources to assist persons who remain in their homes are: homemaker services, attendant care, meals-on-wheels, visiting and public health nursing services. For counseling or social recreation, referrals are made to social casework agencies, senior citizen centers, and friendly visitors.

A significant number of problems (for all the patients) relates to the need for proper medical treatment and medication management. Persons experiencing such problems are referred back to their private physicians, or if they do not have one, and are agreeable, the Project physician secures a physician for them.

Many patients need partial or total care and supervision and these individuals are required to move from their homes. In such cases the best possible placement for the individual and his total needs is primary consideration. It is never a question of arranging a placement because "X" boarding or nursing home happens to have a vacancy.

Primary considerations regarding such placements are: location of home, type of building, religious and other aspects of the home, numbers of men and women residing in the home, type of supervision, personal services, recreation and rehabilitation programs, and medical services available.[11]

For those persons who require skilled nursing services, the Project has successfully utilized a number of nursing homes in San Francisco County and other counties surrounding the area.[12]

---

[11] The Evaluation Form, used by the Project staff in decisions regarding placements in nursing and boarding homes is shown on the following page.

[12] One of the most innovative nursing homes utilized by the Project—Sunny Acres—is described in the appendix of this report. However, for a number of reasons, including shortage of beds, poor quality of care, expense; nursing homes were rarely utilized in the city of San Francisco.

Some nursing homes, in addition to providing skilled nursing services, have demonstrated their ability to care for the confused, disoriented and often times demanding patient.[13] The Project staff is careful, however, in distinguishing between *supervision and care, as opposed to the over-use of medication which, in many such facilities is euphemistically called "successful management."*

Department of Mental Hygiene
State of California

Community Mental Health Services
City and County of San Francisco

GERIATRIC SCREENING PROJECT
800 Potrero Avenue
San Francisco, California 94110

Name of Facility:		X-Ref:
Address:	County:	Telephone:
Owner & Manager:		
Licensed by: County _____ SDSW_____ SDMH_____ SDPH_____		Expiration Date:
Rates:		Capacity: M_____ W_____ Racial: _____ Religion: _____

DESCRIPTION OF FACILITY: Neighborhood, Building, Environment, Social Factors.

DESCRIPTION OF PROGRAM: Supervision, Personal Services, Recreation, Medical.

SOCIAL WORKER'S EVALUATION AND RECOMMENDATIONS: Factual Conclusions, Coding.

DATE OF STUDY:	PSYCHIATRIC SOCIAL WORKER:	VACANCIES:

GSP#118 11-20-64

[13] This conclusion was reached in Rypins, Russel F., M.D. & Clark, Mary Lou, ACSW—"A Screening Project for the Geriatric Mentally Ill"—California Medicine, October, 1968. The authors also said that "the successful demonstration that nursing homes and boarding homes could be utilized as appropriate alternatives" to hospitalization was one of the most meaningful achievements of the project.

Patients who are ambulatory, who require only partial care, and who do not require skilled nursing services, are able to get along adequately in boarding homes. These homes are licensed by the local County Welfare Department to care for no more than six persons. For the most part, this type of facility is not equipped to manage very disturbed patients and certainly not persons who require special diets, or who are uncooperative to the degree that they refuse to accept medication.

The patients who have been committed to State hospitals are those who cannot function adequately in the community and for whom active treatment, previously instituted at the local level, has not resulted in significant improvement. Such previous treatment generally consists of two to six weeks of intensive psychiatric care in a general hospital.

The Project staff recommends the filing of a petition for mental illness only when the patient is unable to care for himself, constituting a danger to himself or others, and when he refuses or is incapable of cooperating in the plan set forth by the staff physicians. If no responsible family member is available, the petition is signed by a representative of the District Attorney. The authority of the Court has frequently proved instrumental in the patient's acceptance of out-of-home placement.

THE PATIENT WHO CANNOT PAY

In any discussion related to providing services to the mentally ill aged, it is important to keep in mind the financial predicament faced by elderly persons in this country.

It is clear by now that low income is the number one problem facing many of the 20 million persons 65 or older in the United States [14]—and recent studies have shown that the older person who is mentally ill tends to be poorer (and sicker) than the rest of the aging population.[15]

California's Medicaid program (Medi-Cal) is proving very helpful to those patients referred to the project from the Old Age Assistance Units of the local county Public Welfare Department (the highest number of referrals). Without this aid, it is doubtful if these persons could have been placed in any but a State institution.

When a patient qualifies, hospitalization in a State mental institution in California is provided by Medi-Cal funds (50 % paid by State and 50 % matching paid by Federal Government).[16]

For patients who do not have sufficient funds to pay for nursing home care and who qualify, the first 100 days are paid by Medicare.[17] Thereafter, if it is necessary for the patient to remain in the nursing home, he may apply to the county Medi-Cal Consultant (there is one Medi-Cal Consultant in every county in the State) for authorization to remain, and funds are then provided by Medi-Cal.

---

[14] In "Economics of Aging: Toward a Full Share in Abundance"—A Working Paper prepared by a Task Force for the Special Committee on Aging, U.S. Senate, p. VII—Facts and Findings.

[15] The Benjamin Rose Institute of Cleveland found in their study of protective services needed by the non-institutionalized aged, that 74% of those persons studied needed temporary, intermittent, or supplemental financial assistance either to pay for medical/psychiatric/social services or to meet the basic maintenance needs of food, clothing and shelter.

[16] Medi-Cal, Medicare, and Old Age Assistance grant information was provided in a telephone interview with Miss Mary Lou Clark, ACSW, Director of the Project.

[17] According to Miss Mary Lou Clark, most patients are low-income elderly, and therefore very few are under the Medicare program.

Because no medical or nursing services are provided in Boarding Homes, financial support cannot be provided by Medicare or Medi-Cal. Those persons who have insufficient funds to pay for their own care receive Old Age Assistance grants for payment of Boarding Home fees.[18]

Funds for home care are provided by Medicare, when the patient qualifies and by the various county welfare departments when he does not.

DRAMATIC RESULTS FROM SCREENING

Geriatric commitments from San Francisco previously numbered almost 500 a year.

> **In its first three calendar years, 1,290 persons were directly served by the Project. The commitments dropped successively in the three years to 40, to 12 and then to 3.[19] Essential to these results were home visits, supportive community resources and a dedicated staff unafraid to cope with the often depressing needs of older people.**

Three hundred and fifty-two persons were screened by the Project in 1967. Of that number only three were committed and all three had previous records of commitment. 26% were placed in nursing homes, 10% in boarding homes, 11% in general hospitals for systemic diseases and 52% were maintained with supportive services, in their own homes.

Of the 1,290 persons who were screened through the Project during its first three calendar years, 4% were committed to State hospitals, 33% were placed in nursing homes, 8% went to boarding homes, 10% were admitted to both county and private medical hospitals and 45% were able to remain in their own homes with supportive services. Only 58 individuals were found to need commitment out of the total number of persons screened through the Project X in the last three and one-half calendar years (1965–1968):

---

[18] See footnote 16.

[19] Table showing reductions from 1962 to first 6 months of 1968 on following page.

ADMISSIONS OF PATIENTS AGED 65 AND OVER TO SAN FRANCISCO COUNTY HOSPITAL AND COMMITMENTS TO STATE HOSPITALS, YEARS 1962–1968

Month of admission	1962		1963		1964		1965		1966		1967		[1] 1968	
	Admissions	Commitments	Admissions	Commitments	Admissions	Commitments	Admissions	Commitments	Admissions	Commitments	Admissions	Commitments	Admissions	Commitments
January	67	49	66	46	67	40	62	6	37	0	30	0	17	1
February	62	37	66	37	52	34	38	4	25	2	24	0	20	1
March	72	50	70	37	54	18	41	5	22	3	21	0	22	0
April	64	46	53	33	78	40	48	3	27	0	28	0	16	0
May	75	34	51	33	67	29	32	2	34	1	26	0	21	1
June	61	34	59	39	55	36	46	4	34	2	17	0	[2] 9	[2] 0
July	51	30	59	41	31	12	41	3	29	1	16	0		
August	85	45	62	38	51	22	33	3	33	0	24	0		
September	55	35	75	52	55	23	32	3	19	0	12	1		
October	59	40	84	39	56	27	35	3	18	2	18	2		
November	68	48	67	43	42	15	32	1	21	1	23	0		
December	61	38	72	35	53	10	33	3	32	0	23	0		
Total	780	486	784	473	661	306	473	40	331	12	262	3	105	3

[1] 1st 6 months of 1968.

[2] Period June 1–15, 1968, inclusive.

The information and consultation services provided by the Project staff alerted the community to the many alternatives to institutionalization, and that it is no longer necessary to commit an elderly relative to the State hospital because the family is unable to deal with his behavior problems.

The Project further demonstrated that alternative care facilities can be utilized successfully in most cases. Careful evaluation of such facilities is essential, as well as continuing social work and medical/psychiatric programs for the patients, if they are to remain in the community.

SOME UNRESOLVED PROBLEMS

It quickly became apparent to the Project staff that the patients preferred to be cared for in their own homes, if at all possible. Only through diligent casework has the Project been able to provide home maintenance for such a high percentage of the individuals referred to them. It is unfortunate that valuable home care services for the older person, such as: home health aides, visiting housekeepers, homemaker services, and meals-on-wheels are in short supply or, simply not available in many communities.

One recent study,[20] utilizing homemaker services for elderly protective cases, found that this type of service offered a genuine alternative to placement (in mental hospital or group care facilities) in many cases and also had considerable promise as a therapeutic service. Some of the persons involved improved remarkably under the care, stimulation and attention of the home aide. "In many instances, the home aide was unquestionably the most important person in the treatment effort."

Alternative placements, such as nursing homes and boarding homes utilized when an individual could not be maintained in his own residence, brought to light some serious problems.

Even yet, many nursing homes simply refuse to accept the mentally impaired patient, or they limit the number of such individuals they will accept. Such patients are considered "difficult" because they often require extra services and personnel. And, as was mentioned earlier, most of the patients are on public assistance and therefore they qualify for Medi-Cal. The Medi-Cal payments barely meet the homes' cost per patient and when extra services are required, the facility cannot afford to accept patients who are indigent as well as mentally impaired. Some nursing homes do accept patients who qualify for Medicare and then, on the 99th day of their stay (100 days is the limit Medicare sets on extended care facilities), call the Project to complain that the patient suddenly "doesn't fit in" and that another placement should be found for him, or that he should be committed to the State hospital. In other words, nursing homes cannot afford to keep indigent patients and do not understand mental disorder. Therefore, they, like many lay persons in the community, feel sure patients should be committed to the State hospital.

Only a handful of patients have been placed in boarding homes. But persons so placed usually face an unhappy existence. In San

---

[20] Margaret Blenkner, D.S.W. In a paper presented at first Workshop on Comprehensive Services for the Geriatric Mental Patient—Washington, D.C., November 30-December 1, 1967—discussing Benjamin Rose Institute of Cleveland's study of protective services needed by non-institutionalized aged.

Francisco County, boarding home rates vary from $179 to $500 a month. Persons with insufficient funds to pay for their own care receive Old Age Assistance grants up to $179 a month. Obviously, very little is left over for personal items, or recreation. The homes provide almost nothing in the way of activity programs; thus, creating a "custodial" situation similar to the back wards of a state hospital.

Standards of care offered in nursing and boarding homes must be raised to provide adequate treatment and care of the mentally impaired patient, and this means increased costs. "Adequate licensing and review procedures for each type of facility, relating to personnel requirements as well as to physical plant facilities, are imperative."[21]

The need for training programs and the upgrading of salaries and experience is especially urgent in relation to nursing personnel who care for the mentally impaired elderly. Operators of boarding homes need training courses, and psychiatric consultative services should be made available to them, and their use encouraged. Unfortunately, there are not enough psychiatrists trained and experienced in working with the elderly mentally ill, and they are not called upon often by those who operate and staff nursing and boarding homes.[22]

Screening programs can only be successful if alternative care facilities for elderly persons develop activity programs that allow for continued growth and involvement.

When such programs (along with necessary medical/psychiatric services) are not available in nursing homes and boarding homes, the facilities are in fact, no more than old style "storage bins."

IMPLICATIONS FOR FUTURE PLANNING—THE FRUITS OF PREVENTION

Mental illness in older persons constitutes not only a mental health problem, but a public health and welfare problem as well. All three areas of professional and community responsibility are involved and must work together. It is obvious that a screening program, without the cooperation of all related public service agencies, is doomed to failure.

If successful, such programs can prevent institutionalization, which is now recognized as an ineffective and often harmful solution to the diverse problems which confront the mentally impaired older person.

The significant contribution of the Geriatric Screening Project, aside from the dramatic reductions in commitments of geriatric patients to State hospitals, is that it offers substantial evidence that many of the problems of the elderly mentally ill can be alleviated by comprehensive home screening teams, providing coordinated services—physical and mental examinations, counseling and placement in *carefully selected* alternative care arrangements.

---

[21] Alexander Simon, M.D., Medical Director, The Langley Porter Neuropsychiatric Institute, Professor and Chairman, Department of Psychiatry, University of California School of Medicine, San Francisco, cited in a letter written to Senator Harrison A. Williams, U.S. Senate Special Committee on Aging, November 14, 1968.

[22] See footnote 21.

69-261 O - 71 - 6

The implications for planning are obvious. Conceivably, thousands of older persons across the nation could avoid commitment to State mental hospitals through geriatric screening programs that follow the San Francisco example, freeing the State mental hospitals to function as treatment centers for persons suffering from acute mental disorders, instead of "warehouses" for the chronically ill.[23]

[23] Dr. Alvin I. Goldfarb, in spoken communication with the Committee staff, has disagreed with the idea of home screening teams. He feels that such teams are biased at the outset because the basic premise from which they operate is to keep old people out of state mental hospitals. Dr. Goldfarb has remarked that if state institutions were strong enough they could effectively conduct screening in the hospital and then make proper alternative placement, if necessary. He did agree, however, that programs such as the San Francisco Geriatric Screening Project can provide a valuable service to older persons, in protecting them against often needless involuntary commitment to state mental institutions. If the screening program also acts as a social agency, educating the community at large to the need for development of other, more therapeutic resources; and as a diagnostic tool, providing immediate treatment and care for the patient, then it can be an effective instrument for social change.

PROJECT STUDY FOUR

HARLEM HOSPITAL OUTPATIENT GERIATRIC PROGRAM: OUTREACH AND GROUP THERAPY IN AN URBAN GHETTO

Upper eastside Manhattan is not one ghetto, but many. High-rise apartment houses, many of them overlooking Harlem River, serve the public housing poor in some neighborhoods and those with "moderate" income in others. Outside the high-rise perimeter, old brownstone and brick tenements still house large families or solitary souls on narrow side streets.

Harlem Hospital, at 136th Street and Lenox Avenue, is the major provider of health care for the 400,000 or so persons who live within forty blocks of its doors. That task, difficult enough in any urban center is all the more intense because of the problems encountered by low-income minority groups: fear of and hostility toward authorities, almost universal neglect of health needs, the unemployment-welfare cycle, and of course, pervasive crime.

What of the elderly Negroes who have intense psychological difficulties in this environment? How can they be reached? How can they be helped?

"By the time these people reach old age," said the Hospital Director of Community Psychiatry, "they no longer have the strength to help themselves. They accept deterioration and ill health as their lot."

And yet, despite the odds against them, approximately 50 black men and women—ranging in age from 55 to 80—are finding the strength to help themselves overcome mental disorders, and they are no longer accepting their "lot." They are participating in the Harlem Hospital Geriatric Group Therapy Program, which must yet be classified as a pilot project with an uncertain future, but which has already managed to overcome hopelessness for those whose later years seemed to offer little else.

INNOVATIONS:

1. "MENTAL HEALTH ASSISTANTS"—NON-PROFESSIONAL WORKERS FROM THE COMMUNITY TRAINED TO AID IN THERAPY SESSIONS, TO PROVIDE OUTREACH AND FOLLOW-UP SERVICES.
2. NO TIME LIMIT. PATIENTS WELCOME TO REMAIN IN PROGRAM INDEFINITELY.
3. OCCUPATIONAL THERAPY, A PART OF GROUP THERAPY SESSIONS.

BACKGROUND

The Negro who is in his 60's today was born at the end of the 19th century, more often than not in the deep South. He has lived for six decades or more in a pattern of discrimination and segregation which taught him not to "push" himself, and never to question the "system." In other words, he has been isolated from the mainstream of social activity all his life.[1]

Harlem, with its high crime rate, heavy incidence of narcotics addiction, large numbers of angry, militant young, is a far cry from the earlier life-style of most of its elderly residents. In order to protect themselves from what they see as a hostile environment, they may become isolated and withdrawn. Most do not take advantage of the local "Golden Age Centers" and other community programs that have sprung up in Harlem, as elsewhere, which enable older persons to participate in educational, recreational and social activities. It is small wonder, then, that an outpatient psychiatric clinic does not reach this population as it should.

The Department of Psychiatry at Harlem Hospital is responsible for providing mental health services to approximately 400,000 persons.[2] Of that number, 7.3% are 65 years of age and over.[3]

The hospital has operated a psychiatric outpatient clinic geared to provide community oriented service for a number of years. However, in spite of the evidence of a significant amount of mental disorder among the older population, only 2.5% of the clinic population is in this age group.[4]

THE NEED: What is needed for this community, is a mental health program that reaches out to meet the *mu.tiple needs* of its elderly residents; a program which informs such persons of available programs and facilities, which encourages their utilization; and which acts as a treatment center.

The Department of Psychiatry had found group therapy successful for other age groups in this disadvantaged community and felt that this approach had potential value for the elderly, as well. The existence of medical and psychiatric outpatient clinics within the hospital complex would provide the elderly participants with necessary additional services. Therefore, it was decided to initiate outpatient

---

[1] A few facts abstracted from the pages of "Double Jeopardy—The Older Negro in America Today," prepared by the National Urban League, 1964, will illustrate some major problems faced by the older Negroes:

7 out of every 10 elderly Negro couples live on less than $3,000 a year, one in two couples have less than $2,000 and one in 10 must exist on less than $1,000 a year.

76.6% of the older Negro men who live alone and 96.5% of the women, have less than $2,000 a year to live on. 45.7% of the men, and 68.5% of the women, live on less than $1,000 a year.

The incidence of death from the leading killers such as heart disease, cancer, brain hemorrhage and accidents, is higher among older Negroes than the overall elderly population.

The elderly among minority groups have received some attention in Senate Committee on Aging studies of recent years, including "Economics of Aging: Toward a Full Share in Abundance," March, 1969, and "Long-Range Program and Research Needs in Aging and Related Fields," December, 1967.

[2] In "Group Therapy Programs with the Socially Deprived in Community Psychiatry", June Jackson Christmas, M.D. and Elizabeth B. Davis, M.D., Paper presented at 22nd Annual Conference of the American Group Psychotherapy Association, San Francisco, California, January, 1965.

[3] In "Outpatient Geriatric Psychiatry in an Urban Ghetto with Non-Professional Workers," Sheldon Zimberg, M.D., Paper presented at 124th Annual Meeting of the American Psychiatric Association, Boston, Massachusetts, May, 1968.

[4] In paper cited in footnote 3.

geriatric group therapy as a pilot project, toward the ideal goal of providing multiple services for this group.

The project was to be built around talk sessions (group therapy) which would primarily serve those older residents in the community who needed but were not receiving mental health care.

A number of factors entered into the decision to use this treatment approach as opposed to the traditional doctor-patient psychiatric treatment:

—Because group therapy is social rather than primarily verbal, the disadvantaged patient can communicate in his own language, rather than the dominant middle-class language,[5] and, he communicates to his own peer group, as well as to the therapist.

—Fear and hostility toward authority has become a way of life for most of these older individuals, and the difficulty experienced in trusting a therapist (who represents authority) is more readily overcome in a group situation, which allows for a gradual development of trust.

—Perhaps the strongest argument in favor of using this approach with disadvantaged older patients is that, in an informal manner, it focuses on immediate, concrete answers to problems. In group therapy, the setting is relaxed. Patients and therapist sit in a circle, and all join in discussing the problems and fears of any one patient. If a patient has, for instance, been having difficulties with his landlord and neighbors, the discussion may bring out the similar problems of another patient. In this way, one problem feeds another, bringing to the fore possible reasons for the difficulty. Solutions arrived at in any one session can be acted upon immediately.[6]

The Geriatric Psychiatry Group program began in September, 1966. Thirty-five persons were screened for suitability for outpatient treatment, and seventeen became active participants.[7] Those persons who were not suitable (psychotics, or those with acute medical disorders) or who refused this type of program, were hospitalized, given more intensive treatment in the hospital's psychiatric outpatient clinic, or provided with other alternatives.

Initial studies revealed that participants were typical of the low-income elderly population. About two-thirds were female, more than half were widowed (only 18% were still married); some 40% lived alone, isolated from any personal relationships; very few were em-

---

[5] The presence at the sessions of the mental health assistants (whose function is explained on p. 79) is a valuable aid to both the patient and the psychiatrist. Since these women are from the same community as the patients and the same social class, they can act as "interpreters" of any of the patients' feelings that the professionals may misunderstand.

[6] The decisionmaking factors described above were abstracted from "Group Therapy Programs with the Socially Deprived in Community Psychiatry," June Jackson Christmas, M.D., and Elizabeth B. Davis, M.D., Paper presented at 22nd Annual Conference of the American Group Psychotherapy Association, San Francisco, California, January, 1965.

Dr. Christmas is Instructor in Psychiatry, Columbia University College of Pysicians and Surgeons; Chief, Group Therapy Program, Department of Psychiatry, Harlem Hospital Center, New York, N.Y.

Dr. Davis is Assistant Clinical Professor of Psychiatry, Columbia University College of Physicians and Surgeons; Director, Department of Psychiatry, Harlem Hospital Center, New York, N.Y.

[7] One more group has been introduced bringing the attendance up to approximately 50 patients; a younger group, aged 55–65 years.

ployed; and the remainder were either collecting Social Security or public welfare. All had constant financial problems.[8]

THE PROGRAM: As of this writing, two separate therapy sessions meet each week during the day. A psychiatric nurse and a mental health assistant accompany the psychiatrist. Cookies, coffee and tea are made available at no charge to the participants.

The therapy sessions are called "discussion groups" to alleviate any fear or embarrassment on the part of the participants.

Referrals are solicited from the various divisions of the Harlem Hospital Center, Department of Psychiatry; other community agencies; and Senior Citizen's Day Centers, Golden Age Clubs, and local block associations [9] in the Harlem community.

Initially, it was hoped that coordination with the Golden Age Centers and Senior Citizens Clubs would supplement the social experience provided by the group therapy sessions, as well as serving as sources of referral. But there was great resistance among the participants to attending other social programs in the community. Even though they came to the group sessions faithfully every week, they would not attend the other social programs near their homes. It soon became clear to the professional staff that the brief social experience provided by the group therapy sessions was very helpful to the patients, and further, that these individuals were not accustomed to the kind of social interaction found at Golden Age Clubs or Day Centers. They had been "isolated" for too long. Soon, the staff stopped trying to influence the participants to attend other programs.

In addition to attending the group therapy sessions, the patients visit the hospital psychiatric clinic (an average of 21 visits per patient during intensive treatment phase) and are accompanied by the mental health assistants to other hospital clinics and social welfare agencies. The patients are visited by staff members and mental health assistants, if they are admitted to an inpatient facility; and they are visited at home, if they do not appear for their clinic appointments or therapy sessions.

Occupational therapy was recently introduced as a part of each group session.[10] The patients are provided with materials to make assorted handicrafts. The staff and the patients have found this additional activity rewarding.

Unlike other such psychiatric programs, there is no time limit to treatment. Patients are welcome to remain in the group therapy program for as long as they wish. The staff has found that the knowledge that there will be no "cut-off" time to treatment provides a feeling of additional security to the older groups. This aspect of the program has proved to be a valuable preventive measure.

The staff remains in contact with patients if and when they leave the group, to assure that medication is continued (if needed) and that the individual's level of functioning is maintained.

---

[8] *Op. Cit.*, footnote 3.

[9] United Block Association. Each neighborhood has its own "problem broker" (paid with Anti-Poverty funds) who operates out of storefronts in the community. Community residents bring their complaints and problems to the "problem broker" and together, they work toward a solution. If an older person displays disturbed behavior, the "problem broker" may refer him to the Harlem Hospital Geriatric Group Therapy Project.

[10] According to Miss Alice Brennan, the Psychiatric Social Worker who now administers the program, occupational therapy activities are available five days a week to all outpatients of the Hospital's Department of Psychiatry. Many of the elderly participants in the Geriatric Group Therapy Project also take part in these on-going activities, in addition to the occupational therapy provided in group sessions.

AN ADDITIONAL ASSET—MENTAL HEALTH ASSISTANTS

When the project began it was staffed with one psychiatrist and a psychiatric nurse on a part-time basis. It soon became obvious that more staff was needed. Another psychiatrist and a social worker were added full-time. One essential component was still lacking: that of coordinated outreach activities, which would, in a sense, pull the program together.

Since the professional staff did not have the time to provide outreach services as well as treatment, and since the hospital had been successful in its use of non-professional workers with other group therapy programs (for other age groups), it was decided to obtain two trainees from the Harlem Domestic Peace Corps and train them to work with geriatric patients. The trainees selected were two middle-aged housewives who were residents of the Harlem community.

After a brief introduction to the field of mental health—which included nontechnical discussions concerning the psychiatric and social problems of the elderly, and three months of on-the-job training provided by the psychiatric nurse—the trainees became a part of the professional team. They were given the title of Mental Health Assistants and have proved to be an invaluable aid to the success of the program.

As was noted earlier, a mental health assistant is present and helps conduct each of the group therapy sessions.

Because they reside in the community, the mental health assistants are able to provide many outreach services to patients that the professional staff cannot, including:

—accompanying patients to other hospital clinics and community agencies for medical care;

—contact with the Department of Social Services (Welfare) caseworkers concerning economic and housing needs of the patients;

—interviewing the patient's friends and relatives;

—home visits and recreational activities.

The home visits have been of particular value in discovering evidence of physical or psychiatric disorder before these become too serious. For example, a patient may become ill or have an accident between the time of one therapy session and another (the groups each meet once a week). If he is not visited during that time, there is no way of knowing about his additional stress. Moreover, many of the patients live alone, isolated from social relationships other than the group sessions. There is always the chance that such persons will not seek help when they become ill. If the time between the sessions is allowed to lapse without contact with the patient, his illness may progress until it is too late to help him in the community. He will either have to be hospitalized or, in extreme cases (and this has happened), he will be found dead by a neighbor or social caseworker.

The mental health assistants have also been able to establish friendships with the patients, who often visit their homes on weekends. In this way, the patients become engaged in helpful personal relationships and often, the mental health assistants are the first real friends the patients have known for many years.

RESULTS: The participants have improved greatly in the three years the program has been in effect.[11] Many with severe psychiatric symptoms at time of screening, such as hallucinations, delusions, confusion, and agitation, have responded well to the treatment, along with relatively small doses of psychiatric drugs.

The friendly, club-like atmosphere of the group therapy sessions, adds much to the patients' level of self-esteem and also contributes to improvement of their functional capacities. For example, the patients feel that the meeting room is their "clubroom" and they have elected officers, such as chairman, treasurer, and secretary.

The groups have been on several outings (usually a movie or dinner in a local restaurant).[12] The participants vote on where they want to go and then a collection is taken which helps defray the cost of the outing. No set fee is required; the patients are asked to donate whatever they can afford. The balance is paid out of the program budget. This type of social activity is yet another important component in the Geriatric Group Therapy Program, and is especially helpful to this group of socially "isolated" aged persons.

The following case histories from the files of the Geriatric Group Therapy Program will best illustrate some of the very tangible and dramatic results that have been achieved by patients participating in this program:

PATIENT I: a 60-year-old widow who had recently come from Virginia to live with her married daughter. She was unable to get along with her son-in-law and developed an agitated depression. She was referred to the group from the hospital's psychiatric emergency ward and found to be in need of hospitalization. After treatment on the general hospital psychiatric ward, her behavior symptoms were alleviated. Prior to discharge, an apartment was found near her daughter with the help of one of the mental health assistants, and she was started in a geriatric group. She continued with the group after her discharge and has attended practically every session. This patient was recently elected treasurer of her group.

PATIENT II: a 70-year-old retired longshoreman who was suffering from hallucinations and confusion. He was referred to the program by the hospital psychiatric emergency staff. When seen initially he was in a physically debilitated state and was suffering from incontinence in addition to his psychotic symptoms. He was attempting to get work on the docks and would not accept his physical inability to do the work. He was given medication and was taken to medical and urology clinics by the mental health assistants and had several general hospital admissions to deal with his physical condition. Gradually, his health improved and his confusion cleared. He attended most of the group sessions, made several friends in the group, and has accepted his retirement.

PATIENT III: a 64-year-old widower, retired railroad mechanic who was living with his son. He was referred by the local Block Asso-

---

[11] The participants have also experienced improvement in their physical health. This can be attributed to the fact that the program does not limit its focus to psychiatric treatment alone, but establishes a system of multiple, coordinated services.

[12] Both groups interact at parties and outings, and all group "members" know one another.

ciation because of depression, excessive use of alcohol, and a tendency to give money to strangers. It was noted that he had been severely depressed since his wife's death and his retirement from his job. He became involved with the group and was started on antidepressant medication. He responded quickly to the medication, stopped drinking, and became an enthusiastic participant in the group. He was visited at home several times by one of the mental health assistants and she was able to improve the strained relationship the patient had with his son as a result of his disorder.[13]

CONCLUSION—AND SOME THOUGHTS ON THE FUTURE

This program has admittedly, only begun to cope with the mental health problems of the community's aging residents. It is an important and hopeful step forward. The program has illustrated:

—**That if mentally ill elderly individuals are made aware of the services available to them, and accompanied to the various social agencies and medical clinics, they will take advantage of them.**

—**That group therapy as a problem-solving technique can provide older disadvantaged patients with concrete answers to their immediate problems and also allows them to see themselves as social beings within a society, rather than outside of the society.**

The Outpatient Geriatric Program serves only a handful of patients and there is an urgent need for an expansion of the program. A miniscule staff of one professional and two non-professional workers can hardly be expected to handle all of the outreach, treatment, and educational services that are needed to assure Harlem's elderly citizens of comprehensive mental health care.[14]

Desperately needed in this community is a more coordinated system of those services to the elderly that already exist and development of facilities and programs that are in short supply or are not available. For example:

HOME CARE: Harlem Hospital operates a home care unit that has been very successful in helping to maintain chronically ill older persons (many of whom are also mentally impaired) in their homes after release from the hospital. The home care unit is staffed with a medical director, physicians, social workers, nurses, and a physical therapist, along with a psychiatric consultant. These professionals are available to provide evaluation and diagnosis in the patient's home, if necessary. Innovative as this program is, "it is extremely limited and does not even come close to serving all the elderly persons in the community who would welcome such a service."[15]

---

[13] The case histories noted above were abstracted from "Outpatient Geriatric Psychiatry in an Urban Ghetto with Non-Professional Workers," Sheldon Zimberg, M.D., Paper presented at 124th Annual Meeting of the APA, Boston, Massachusetts, May, 1968. Dr. Zimberg was the Director of Community Psychiatry at Harlem Hospital until October, 1969. He was one of the originators of the project.

[14] Originally, the staff of the Project consisted of five professionals and two non-professionals (Mental Health aides), but due to a lack of funds, early last year the staff was cut back to one professional—a psychiatric social worker who administers the program—and two full time mental health aides.

[15] In spoken communication with Miss Sherry Roseneck, R.N. Miss Roseneck is a Psychiatric Nurse and was one of the administrators of the program. With the program since its inception, Miss Roseneck left the project late in 1969.

NURSING HOME FACILITIES: *No nursing home is available to serve this community*. Naturally, the elderly residents of Harlem are free to go to nursing homes in other areas of the city, but for the most part, they prefer to remain close to family and friends. In addition, since most nursing homes are profit-making institutions, these individuals, from the lowest income bracket, can ill-afford the high rates asked in such facilities. The Committee was informed by the Psychiatric Nurse on the staff of the Harlem Hospital Geriatric Group Therapy Program that "the nursing homes in New York City that accept welfare patients are appallingly overcrowded and the waiting lists are so long that they are useless to the patient who must have immediate medical attention in a protective care setting." [16]

"What happens to the aged Negro who is ill or infirm and has no one to care for him?" [17] The staff of the Geriatric Group Therapy Program has supplied the Committee with an example of what can happen in Harlem.

A 67-year-old woman was brought to the attention of the Project staff. She was living with her 50-year-old nephew, who was her only living relative. The woman had no income and was receiving welfare payments. She had begun to show signs of mental impairment, including loss of memory and wandering through the streets without paying attention to traffic lights. Her mental condition was complicated by physical disability. Suspicion of tuberculosis had shown up on her X-rays (taken at the hospital clinic). She suffered from hardening of the arteries, making it difficult to walk. Her nephew worked and could not stay home to care for her, or bring her to the hospital for treatment.

The Geriatric Group Therapy Project accepts only those persons who are ambulatory, and could not take this woman into the group therapy sessions. [18] The patient could have fit the criteria for admission to a nursing home. However, no home was available. The last resort was commitment to a State mental hospital. (A recent State law has narrowed the criteria for admission of elderly mentally ill persons to State hospitals.)[19]

This was hardly the best solution but it was the *only one available*.

FOSTER HOMES: Over the years there have been a number of foster home programs in New York City and they have been highly publicized as an answer to the problems of older persons who live alone. This is only partly true. Foster Home programs are successful with the comparatively "well" aged, but they in no way answer the needs of the aged physically and/or mentally ill person who lives alone. The sponsors of these homes are paid a sum by the City to provide food, shelter, and companionship. They cannot be expected to have the training, the time, or the facilities needed to cope with the multiple needs of the mentally and/or physically disabled person.

---

[16] Spoken communication with Miss Sherry Roseneck, R.N. Miss Roseneck went on to say that a nursing home is planned for Harlem, but it will not be completed for approximately 2-3 years.

[17] Miss Jeweldean Jones, Associate Director of the National Urban League, answered her own question when she testified before the Senate Committee on Aging hearings on "Long-Range Program and Research Needs in Aging and Related Fields" in December, 1967: "State after State has indicated in reports and other documents that, because there is literally no other place for them to go, chronically ill Negroes have been condemned to live out their lives in custodial care mental hospitals."

[18] Many of the participants in the Group Therapy sessions have physical disorders along with their mental problems, but they are all ambulatory and their physical disabilities can be treated in the hospital clinics, or in-patient facilities.

[19] Spoken communication with Miss Sherry Roseneck, R.N., Psychiatric Nurse formerly on the staff of Geriatric Group Therapy Project.

STATE HOSPITALS: As was mentioned earlier, large numbers of this aging population are alone with no family to care for them and many of the chronically ill spend their remaining years in state mental hospitals. While this is hardly an ideal situation, these people have at least been assured some kind of basic food and shelter in the institution.

A number of states have moved, during the past ten years, to correct the practice of "dumping" the chronically ill indigent elderly in state hospitals in order to alleviate the overcrowded conditions in such institutions and to provide more adequate treatment and care for those persons who are actually mentally ill. Unfortunately, this action has not generally been accompanied by the development of community treatment centers or protective care facilities to care for this group.[20] The efforts that have been made along these lines have been sporadic and at best have served only handfuls of elderly persons. The chronically ill elderly who were formerly (or are potential) patients in state hospitals have either been left to fend for themselves in the community or have been placed indiscriminately in nursing homes or boarding homes (where they remain for life) with little or no thought given to the kind of care, treatment, or rehabilitation programs provided in these facilities.[21]

New York State has recently joined the movement to exclude the chronically ill elderly from state hospitals, with disastrous results for the aging population we are discussing in this chapter.

In June 1968, the New York State Department of Mental Hygiene issued a directive which excludes patients from state hospitals when their problems are primarily social, medical, or financial and also excludes older patients with chronic psychiatric disorders [22] and arteriosclerotic brain syndrome. "It is estimated that of the 2,000 persons a year affected by this policy, many will remain in very expensive acute hospital beds, or return to their single dwellings to continue through the 'revolving door process' of community health care."[23]

When there is no place in the community for those mentally and/or physically impaired persons who are "excluded" from treatment in state hospitals, a bad situation is made worse; and ultimately, the

---

[20] One of the states which has established a network of services for this group is North Carolina. See Project Study Two, p. 51 for a description of this program.

[21] Dr. Alvin I. Goldfarb, in "Implications for Policy and Practice," *American Psychiatric Association Psychiatric Research Report*, February 1968, describes the problem this way:

"The disorders for which the chronologically aged go to institutions are highly varied . . . These people need a wide range of services for thier continued care. There is no one kind of facility that will meet their requirements, and the discouraging aspect of planning is that someone is always pointing to this or that method of care for aged persons as though it, alone, were the answer to all the problems. One block to effective planning is the tendency of people to think in terms of 'alternatives' to the institution or 'alternatives' to the state hospital, as if keeping patients out would reduce their need for care. Some years ago, this caused great difficulties in planning because such thinking led to false expectations and hampered steps toward real solutions. Actually, the proponents of such movements would select the persons who had aged in the hospitals and send them to nursing homes where they continued to make good institutional adjustment. This would then be pointed to as a solution to the problem of care for the aged persons in state hospitals, forgetting the real problem that confronts us is that of first admissions in old age to state hospitals, patients who require treatment that differs greatly from that for hospitalized, lifelong mentally ill patients now reaching old age. Yet legislators, hospital directors, and lobbyists have seized upon this idea as a great answer to one of the pressing problems of caring for the aged."

Dr. Goldfarb is an Associate Professor of Psychiatry, at New York Medical College, New School of Psychiatry; Chief of Neuropsychiatry, Home for Aged-Infirm Hebrews, New York; and Consultant on Services for the Aged, State of New York, Department of Mental Hygiene.

[22] Chronic brain syndrome is considered a chronic psychiatric disorder as opposed to arteriosclerotic brain syndrome, which is organic. See Glossary, p. 183, for description of terms.

[23] James G. Haughton, M.D., First Deputy Administrator, City of New York Health Services Administration, in a statement before the Special Committee on Aging, U.S. Senate, "Health Aspects of the Economics of Aging," July 18, 1969, Washington, D.C., pt. 3, p. 612.

state suffers an even greater financial burden. In States which place former elderly state hospital patients in nursing homes, the facilities quickly become crowded with persons who are taking beds away from the chronically physically ill patients who need them.

THE FUTURE: The Geriatric Outpatient Program at Harlem Hospital has established a degree of trust in the community. Trust is measured in a community such as Harlem when persons who live in the area begin bringing in their older relatives and friends for treatment, or when indigenous community organizations[24] begin to refer older persons to the Program. Word of mouth is the most effective method of communication in such a community and good news (or bad) about a service agency travels fast. When the news is good, as it has been with the Geriatric Outpatient Program, people who, in the past may have refused to come in for treatment, make the effort to come, or to inform their neighbors of the service.

As was mentioned earlier, the ideal goal of the Program was to take the first step toward providing a system of multi-services for older persons. Because of limited funds and staff, this has yet to be accomplished for the great number of elderly who do not (or cannot) make use of the Program.

Since Harlem Hospital is the center of health care for this community, a possible program of assuring this group of elderly persons adequate mental health care, might be to use the Geriatric Outpatient Group Therapy Program as a base for a network of services:

—Additional mental health assistants could inform the community, through appearances at Block Association meetings, Senior Citizens Centers, and meetings held in Public Housing Projects, of this and other mental health programs (such as the Harlem Hospital Outpatient Clinic) in the area. They could also be made available for friendly visiting to those older individuals in the community who live alone, but do not (wish to or need to) participate in the Group Therapy Program, and then report any symptoms of mental and/or physical disorder to the Hospital. In addition, the mental health assistants could escort such persons to other health care services and social agencies in the community.

—Closer coordination with the Hospital's Home Care unit, with additional professional staff, who would be available for home diagnosis and evaluation, and non-professional staff, trained to work with the elderly, who could act as "companions" to home-bound persons.

—Liaison established with other health care and social agencies in the community, perhaps with units set up to educate the personnel in these agencies, to the mental health problems of the elderly.

Perhaps other, more workable approaches could be developed, but some coordinated action must be taken quickly. As it stands, the situation in this urban ghetto area of the largest city in the Nation is a desperate one for its older residents.

[24] The description of an indigenous community agency is that which employs and serves only persons residing in a particular community. The Hospital staff has only recently begun to receive large numbers of referrals from these agencies. For example, the Block Association at first sent only one or two individuals to the Program and now they refer all "problem" elderly cases to the Program. The Dominican Sisters (a nursing order), who work out of an office in Harlem and serve only Harlem, work closely with the Program.

PROJECT STUDY FIVE

SWOPE RIDGE NURSING HOME: PREVENTION AND REHABILITATION

The prevailing public image of the nursing home is that of a place where old people wait for death. Families rush through dutiful Sunday visits, eager to be away from the depressing atmosphere, and older residents too often appear to wait out their days in almost apologetic hopelessness.

Though nursing homes have traditionally cared for the chronically ill, the disabled and the mentally impaired elderly, even the best of these facilities have provided little in the way of therapeutic or social activities, arguing that since their patients are among the oldest, and most impaired of the elderly population, the best one can offer them is nursing care, some medical attention, cleanliness, comfort, food and kindness—until they die.

Swope Ridge, a non-profit nursing home in Kansas City, Missouri, has been challenging this concept of custodial care since it opened its doors in 1957. At Swope Ridge, the mood and purpose are far different from the great majority of nursing homes across the country. That purpose is reflected in the words of the Executive Director of the Home. "No resident of Swope Ridge is admitted with the idea that he is a 'terminal patient.' The emphasis is on rehabilitation—not vegetation. Residents come to this home to live, not to die."

Swope Ridge offers each resident a range of physical and psychosocial therapeutic programs designed to foster mental and physical health. Here residents are encouraged to satisfy their needs for work, recreation, education, religious expression, social and personal relationships, as independently as they might in the outside community.

Meaningful social activity is basic to the mental health of the elderly, as with any age group. When such activities are linked with physical and psychological therapy programs, administered by a staff trained to understand and treat special problems, even the oldest, sickest and most disabled elderly patients can hope for improvement.

INNOVATIONS:

1. PHYSICAL THERAPY, INCLUDING CALISTHENICS, PROVIDED AT NO EXTRA CHARGE.
2. OCCUPATIONAL AND SPEECH THERAPY PROGRAMS, AVAILABLE FIVE DAYS A WEEK.
3. DIVERSIONAL ACTIVITIES TWELVE HOURS A DAY, MONDAY THROUGH FRIDAY, WITH REGULARLY SCHEDULED EVENTS ON WEEKENDS.
4. ONGOING STAFF TRAINING AN INTEGRAL PART OF THE TREATMENT PROGRAM (AT ALL LEVELS).

5. RESIDENTS' COUNCIL TO GIVE PATIENTS A VOICE IN MANAGEMENT AND PLANNING.

6. OUTPATIENT CLINIC WHICH OFFERS PHYSICAL AND OCCUPATIONAL THERAPY TO COMMUNITY ELDERLY, AS WELL AS OPPORTUNITY TO PARTICIPATE IN SOCIAL ACTIVITIES.

THE NURSING HOME'S ROLE IN MENTAL HEALTH

The National Institute of Mental Health has estimated that 55% of the residents in nursing homes and related facilities serving the chronically ill are mentally impaired persons.[1] [2]

Elderly individuals are admitted to such facilities because they are disabled, chronically ill and mentally impaired. Moreover, the decision to enter the home rarely rests with the person being admitted. It is made for him by his physician, his family, or a welfare ca eworker. Thus, the patient often feels he is being "put away." Any one, or all of these problems may bring on mental disorder along with feelings of isolation, abandonment and fear, which frequently accompany admittance to a nursing home.

What is needed to help such persons maintain mental health (and to prevent decline), is a way of life as similar as possible to that in the outside community.

The components contributing to "life" in a nursing home have been described as:

1. "Maintenance of biological life and health;
2. "A climate and physical atmosphere designed to communicate a view of each elderly person as a unique and dignified individual;
3. "Provision of life-enriching and life-enhancing services to help the . . . individual live with full realization of his potential for enjoyment." [3]

SWOPE RIDGE—A WAY OF LIFE

Upon admittance to this facility, the new patient is made to feel welcome and "at home"—not "in a home." He is immediately brought into social activities designed to assure him that he is still a member of the community—not apart from it. In other words, the patient is provided with a way of life. All of the treatment and care he receives is developed from that premise.

Shortly after the Home opened in 1957, a consulting psychiatrist[4] was engaged. His duties: met with the Directors of the Home and other key personnel to help develop therapeutic activity programs and to be available for personal consultation with patients. He was also present at training sessions with staff members in order to familiarize them with problems that may arise with mentally impaired patients.

At Swope Ridge, all patients—no matter what the level of mental or physical impairment—are provided with an active way of life every day of the week.

---

[1] NIMH Report on Activities 1968.

[2] In preparation for this chapter, the Committee visited and conducted interviews at five nursing homes who have pioneered in offering specialized care to the mentally impaired, and received evidence that 55% may be a conservative estimate. In answer to the question, "what percentage of your patient population is mentally impaired?" the reply was never lower than 75%. Swope Ridge Nursing Home reports that 80% of the entire Home population is mentally impaired to some degree, 40% severely.

[3] As cited in "Institutional Settings: Nursing Homes and Other Congregate Care Facilities", Elaine M. Brody, ACSW, Lecture presented at University of Southern California 1969 Summer Institute for Advanced study in Gerontology, July 16, 1969.

[4] Dr. Robert Dovenmuehle was consulting psychiatrist at Swope Ridge until late 1969. The Home is in the process of acquiring the services of another psychiatrist. In the meantime, consulting psychiatrists from the teaching staff of the University of Missouri provide the services listed above.

A PHYSICAL ENVIRONMENT DESIGNED TO PROMOTE SOCIAL ACTIVITY

The focal point of this 50,000 square foot building is the activity area. All of the living areas, residential wings and lounges (living rooms), surround a sheltered patio, which opens into a "social center." The social center includes the central dining room, two lounges, and a large, multi-purpose room which serves as an auditorium, chapel, social hall, hobby shop and recreation room. A recent annex is equipped with its own lounges and patios, to enable the most severely mentally and physically impaired patients (who are housed here) to participate in recreational and social activities. The physical therapy department (recently expanded), beauty and barber shops, are on the lower (or basement) level.

A unique aspect of this structure is the residential dwelling located directly next door, and connected to the home by a corridor. The directors of Swope Ridge make their home here, thereby becoming an integral part of the "life" of the nursing home itself.[5]

A building such as this, designed for social and therapeutic activity, is the first step in alleviating the patients' feelings of isolation and fear. The activity areas are but a few steps from each resident's room. It is difficult to avoid social interraction in such a setting.

PRIMARY PHASE—PHYSICAL REHABILITATION

Nothing is so discouraging to a person (of any age) as physical disability. To the older person who was once an active, vigorous human being, the loss of previously-held skills can be devastating.

Even the smallest gains can have a positive effect on the emotional outlook of older patients. Therefore, Physical Therapy is considered the primary phase of the rehabilitation program at Swope Ridge. This service has been offered at no extra charge since 1964 (before that time it was provided for an additional charge, upon a physician's recommendation). The director of the home believes that physicians now feel freer to prescribe this treatment, knowing that no extra charge is involved.

Prior to 1964, fewer than 20% of the patients participated in the physical therapy program. Today, 80% participate and physical therapy is provided five days a week.[6]

A calisthenics program is provided to all patients, no matter what their level of disability. The exercises are geared to individual needs, and they range from very mild for the most severely impaired, to quite strenuous for those who can (and wish to) participate. Dance classes are provided as part of the calisthenics program—even for those who manipulate wheelchairs for Folk dancing.

Speech therapy [7] is available at the Home (supervised by qualified professionals). Speech therapy takes place every day and has proved especially helpful to victims of stroke (who are frequently mentally

---

[5] The living room of the director's home is often the setting for training sessions and serves as a general "get together" spot for staff members.

[6] The Physical Therapy staff is headed by a registered physical therapist who has pioneered in the use and development of physical therapy aids. This program has shown dramatic results: Since 1964 the percentage of patients discharged to their own homes has risen to 40%. The average length of stay has been cut almost in half.

[7] See glossary, p. 183, for description of Speech Therapy.

impaired). A number of patients, who were never expected to speak again, have shown remarkable recovery of speech through this continuous treatment program.

Inhalation therapy is yet another innovative aspect of the physical therapy program at Swope Ridge, and provides an opportunity for physical rehabilitation to tuberculosis patients and persons suffering from Emphysema.

AN OPPORTUNITY TO LEARN NEW SKILLS, AND RE-LEARN OLD ONES

Occupational therapy is an integral part of the Home's activity program. The two occupational therapists direct sheltered workshop activities (similar to Milieu Therapy at Ypsilanti, but on a smaller scale) and other such programs. This treatment serves a definite psychological purpose. For example, the woman who once was a skilled seamstress but can no longer use her hands, or the man who was once a skilled laborer but can no longer attempt such strenuous activity, have been deprived of skills which gave them a feeling of worth, of usefulness. The re-learning of such skills, or the training for new ones, can do much to rebuild their damaged feelings and can also prevent depression and dependence.

RECREATIONAL ACTIVITIES[8] THAT PROVIDE A REASON FOR LIVING

Many nursing homes are medically rehabilitative and a number have introduced physical therapy programs, but few supplement these services with meaningful psycho-social[9] activities. It is this type of supplemental activity that can provide the older patient with a psychological reason for living and improving.[10]

At Swope Ridge, the term, "Diversional activities" describes a wide variety of psycho-social programs. At breakfast each day in the central dining room, the director of the Home broadcasts the "News of the Day" over the loudspeaker, reading from the daily newspaper. This creates breakfast table conversation among the patients and staff, and helps bring the outside world into the nursing home. The broadcast also reaches those patients who cannot take their meals in the dining room. Nurses and nurses' aides have been encouraged to discuss the news with these patients, as they are helping them with their morning meal, so that they, too, may begin their day with friendly and meaningful conversation.

[8] A research project funded by Title III in 1967 AoA Grant is underway at Swope Ridge. Goals of the 3-year project are: To develop a coordinated approach to diversional activities program; to publish a manual for use by other nursing homes across the country; to study training requirements for persons directing such programs and to develop a curriculum guide for use in educational institutions; and to test the program in another nursing home to see whether such activities can be established, using Swope Ridge's concepts and materials.

On September 15, 1969, Mr. Bert Incani, executive director of Swope Ridge was awarded a citation from the National Therapeutic Recreation Society, for developing recreational programs for elderly nursing home residents. This was the first time the Society had given an award for work in the field of aging.

[9] Psycho-social activities are defined here as those recreational programs which are based on relationships with patients and staff members and serve a therapeutic as well as strictly "recreational" purpose.

[10] Abstracted from, "A Multi-Faceted Study of Nursing Homes"—Proposal paper prepared by Leonard E. Gottesman, Ph. D., Associate Professor of Psychology, University of Michigan-Wayne State University, Institute of Gerontology—October 1969.

A listing of the activities offered during one month (each month a new Calendar of Events is posted on the bulletin board outside the Social Center, and sent to families of the patients) from the Calendar of Events, will best illustrate the range of services available at Swope Ridge:

HIGHLIGHTS OF THE MONTH, APRIL 1969

(All activities at 7:00 p.m. unless notified otherwise)

1—What's Cookin'—session in Hobby House
2—Spring Fashion Show (2:30 p.m.)
2—"Artist with a Camera", Slides by Bob Cunningham, professional photographer
3—(PASSOVER) Movie Nite: "He Is Risen"; "On This Mountain" (King Solomon)
4—(GOOD FRIDAY) Easter Egg Dye in Hobby House—daytime (No evening program)
6—(EASTER)
7—Come Play Guggenheim (quiz nite)
8—Lecture—Rae Ann Nixon, Costume Curator, K.C. Museum—slides and display of Victorian costumes
9—Program in Terrace Annex
10—Movie Nite: "Dynamic Maturity"; "The Name of the Game is Fun!"
11—Joan Lang Dance Studio
13—"An Evening with Kay Dennis" (7:00 p.m.)
14—Birthday Party honoring Harriet Tompkins, Betty LaBar, Mary Fryer, Blanche Sartaine, Marion Imbs, Myrtle Pederson, Marion Drought, Georgene Kynette, Elanor Kennaley, Nathan Fischer, Pauline Banta, Vita Saladino and Katharine Ridgway. Musical entertainment by Edna Lashbrooke.
15—"The Good Old Days"—L. W. Henderson, Downtowners Toastmasters Club
17—Feature Film: "The Gunfighter" (6:30 p.m.)
18—Sports/games—bowling and others
21—Spring Arts Festival begins—Southeast High Drama Presentation
22—Accordian Ensemble, drum, guitar—Pauline Wright Music Studio, students 8–13 yrs.
23—Loretto High Glee Club—60 girls
24—Movie Nite: "Sunkist in Motion"; "Building the Golden Gate Bridge"
25—Residents' Sing-a-Long/Talent Show
28—Surprise program
29—Book Review—Margaret Hart, Head Librarian, Southeast Library
30—Out-trip: Drive thru Swope and Loose Parks

REGULAR ACTIVITIES

Question of the Week.
News of the Day: 8:15 A.M. to 8:45 A.M.—Every Morning.
Hobby House: 9:00 A.M. to 4:30 P.M.—Mon. thru Sat.
Physical Therapy: 9:00 A.M. to 4:00 P.M.—Mon. thru Fri.
Current Events Class: 10:30 A.M. to 11:30 A.M.—Tues.
Book Reading: 2:30 P.M. to 3:15 P.M.—Mon. thru Fri.
Music Appreciation in Terrace Annex: 2:30 P.M. to 3:30 P.M.—Friday.
Room Visits/Craft Cart: Afternoons—Mon. thru Fri.
Terrace Annex Fellowship: 3:15 P.M. to 4:00 P.M.—Mon. thru Fri.
Group Exercises: 3:30 P.M. to 4:00 P.M.—Mon.-Wed.-Fri.
Chinese Culture Class:[1] 4:00 P.M. to 5:00 P.M.—Friday.
Bingo: 2:30 P.M. to 4:00 P.M.—Every Saturday.
Use the Library: Every Day.

---

[1] The University of Missouri provides teachers on a variety of subjects to lecture at the Home. Some of the classes include: music, literature, comparative religion, sewing, and music appreciation. The Recreation Director informed the Committee that Chinese Culture was the most popular class.

RELIGIOUS SERVICES EVERY SUNDAY

Catholic Mass, 11:00 a.m.: Father Imbs
Protestant Services, 3:00 p.m.:
April 6—Rev. Gene Barnes
April 13—Rev. William Klein
April 20—Rev. Charles Clark
April 27—Dr. Harold Stine

RESIDENTS' COUNCIL MEETINGS

April 1—Residents' Council, 3:30 p.m.
April 8—Recreation/Hobby Committee, 4:00 p.m.
April 9—Education Committee, 4:00 p.m.
April 16—Religion Committee, 4:00 p.m.
April 23—Food Committee, 4:00 p.m.
April 24—Building/Grounds Committee, 4:00 p.m.

Some other unusual programs include:

—Audio Visual: Slides, showing scrapbooks and albums representing a patient's lifetime hobby, such as stamp collecting or photography, may provide an evening's entertainment.
—Ballroom dances for all residents who wish to attend—even those who are wheelchair-bound.[11]
—Discussion groups: Once a month, the Home invites local "celebrities" (civic leaders, television personalities) to come and head the discussion.
—Dramatics: Residents put on playlets, poetry readings.
—Gardening: During warm weather, members of the resident Garden Club work in the patios, planting flowers and bushes. The plants are brought indoors during winter months so that gardening may continue throughout the year.
—Sports events: Wheelchair races, and ballgames.
—Outings: Occasional night club trips are offered to those who are able to drink (physician's recommendation).[12]

The purpose behind all activities is to motivate the residents to an active participation in the affairs of the world—both inside and outside the Home. As the activities list indicates, several events occur simultaneously. This is planned so residents may have a choice and vary their routine occasionally, just as they would if they lived in the outside community. Every effort is made to encourage freedom and to avoid regimentation.

A ROLE IN THE DECISION-MAKING PROCESS

When an elderly individual enters a nursing home, his feelings of status and self-worth are usually at low ebb. As was mentioned earlier, he most likely has no say in the decision to place him in the Home. In order for these feelings to be strengthened, it is important that the patient have a voice in the management of his new "home."

The Residents' Council at Swope Ridge gives each resident a role in the decision-making process through committee participation, and encourages them to perform voluntarily, some function that is useful to others. The

[11] Ballroom dancing is a great favorite with the patients. The Resident Council recently voted to include dance classes in the activities program.
[12] All activities require a physician's recommendation. The Home informed the Committee that physicians have been quite enthusiastic about allowing their patients to participate.

Council consists of a chairman, secretary, and the heads of seven committees, who meet with the Executive Director of the Home to point out needs and suggest improvements.

The Recreation Committee meets with the Recreation Director to help organize and plan social events, such as entertainment, birthday parties, theater parties outside the Home, sing-a-longs, picnics and other outings.

The Hobby and Crafts Committee is made up of individuals who have (or have had) special skills in this area. They are actively involved in the planning of the program, and also encourage other residents to participate.

A Hospitality Committee escorts visitors on tours of the Home, and staffs the information desk and gift nook (where residents' handiwork is sold).

The Food Committee meets with the Dietitian to help plan menus for the week, informing her of special or favorite dishes other residents may have suggested.

Religious Committee members remind residents of the various religious services available and also help the most severely impaired residents attend. Clergymen from Protestant, Catholic and Jewish faiths conduct services on a voluntary basis.

A Welcoming Committee calls on new residents to acquaint them with Swope Ridge, helping make them feel "at home" soon after admission.

The "Guys and Dolls" Committee gathers news and helps write the bi-monthly newspaper.

The Council and Committee members are not selected by the staff because they are the "healthiest" residents. They are elected by all residents in the Home, and many are wheelchair-bound.

A VOLUNTEER PROGRAM THAT BRINGS THE COMMUNITY INTO THE NURSING HOME

Perhaps the greatest barrier to the mental health of an institutionalized patient (and nursing homes are also institutions) is isolation. He often feels "put away," and abandoned by family and friends. This feeling of isolation can lead to depression, dependence, confusion and finally, complete withdrawal from the world around him. Sunday visits from the family are not enough to prevent deterioriation.

Swope Ridge has long made a practice of opening its doors to family and friends any time they wish to visit and patients are frequently taken out into the community on field trips.

But the administrators of the Home recognized that even this was not enough. What was needed was constant participation in the home's activities by community residents—of all ages.

Therefore, in 1964 a Volunteer Program was developed with community organizations, such as girl scouts, boy scouts, teenage service groups, and church organizations. The home has more than 250 volunteers under the supervision of a paid Director of Volunteers. The volunteer training program has been accepted by the Red Cross. Outside community organizations are also brought into the

program through the use of the Swope Ridge Volunteer Community Advisory Board.

Volunteers meet with the Recreational Director to help plan special activities and they also participate in many of the home's diversional activity programs.

The Director of Swope Ridge reports that this program not only helps break down the "invisible wall, separating patients from other human beings, and the home from the rest of the community," [13] it has done much to dispel the stigma attached to nursing homes and to create greater understanding in the community of the problems faced by elderly individuals.

The description of the wide range of therapeutic physical and psychosocial activities available at Swope Ridge serves to illustrate how one nursing home has gone beyond the limits of providing mere survival, existence and nursing care to its residents. It has truly established a way of life, and a reason for living.

It is important to remember that we are discussing a facility whose primary function is the care of chronically ill, disabled, and mentally impaired elderly persons. *And that the average age of its residents is 82 years.*

The patient who resides in such a setting is encouraged to want to improve, to become involved, and to look forward to tomorrow. The patient residing in most nursing homes faces a far different existence. For him, tomorrow stretches ahead, a bleak and endless repetition of yesterday.

COMMITMENT TO LEARNING—A WELL-TRAINED STAFF

The achievements which can be gained from providing comprehensive, life-giving care to nursing home residents can be great, but such care cannot be achieved without the services of a well-trained professional staff and an effective in-service training program for all levels of staff. The success of any therapeutic program depends to a great extent on those who administer the therapy and care for the patients.

At Swope Ridge, the entire staff is exposed to a continuous in-service education program.

The Director of Physical Therapy conducts weekly training sessions [14] to keep the nursing staff abreast of new techniques so that they may offer physically therapeutic services to the patients continuously. For example, the nurse, or nurses' aide may help the resident exercise upon waking in the morning, to loosen up brittle joints and sore muscles, help patients move properly, while escorting them to meals or activities, remind patients suffering from emphysema or tuberculosis to breathe correctly, or work on a patient's speech defects while engaged in idle conversation.

This continuous therapy is not only physically rehabilitative, but fosters hope and a healthy attitude toward life.

---

[13] Spoken communication with Mr. Albert G. Incani, Executive Director of Swope Ridge Nursing Home. Mr. Incani is Vice President of the Health Planning Council of Kansas City Metropolitan Region and is Chairman of the Missouri Association of Licensed Nursing Homes Committee on Volunteers.

[14] A number of nurses aides are being trained to act as Physical Therapy Aides.

A nursing instructor from the University of Missouri conducts training classes for nurses aides (approximately 60 hours a month). The classes instruct not only in the administration of drugs and treatments, but are designed to orient the staff to the unique physical and mental problems of the elderly residents.

The professional personnel at Swope Ridge conduct classes during employees' off-duty hours, enabling those who are high-school dropouts to earn the equivalent of a high school diploma.

Scholarship aid is arranged for employees while on leave to attend one of the local schools of health-field professions. The Home pays tuition and stipends so aides can participate in nurses training. An organization of long-time personnel, sponsors fund-raising projects to finance this higher education for fellow employees.

Human Relations Seminars are presented at Swope Ridge by the University of Missouri, to help improve working relationships among employees.

The entire staff meets periodically with psychologists from the University of Missouri, to discuss ways of dealing with the mentally impaired residents and methods of preventing decline.

Caring for nursing home patients is difficult, demanding and often frustrating. In-service education programs, along with providing a well-trained staff, challenge nursing home personnel to go beyond "tender-loving-care" to rehabilitative and restorative therapy.

A NEW DIMENSION—OUTPATIENT SERVICES

Large numbers of elderly persons residing in the community are in need of services—psychiatric, medical, and social—but for a variety of reasons (discussed earlier) are not receiving them. The administrators of Swope Ridge have been aware of this problem in their community for some time and have therefore decided to open the doors of the nursing home to elderly individuals in the community who may be in need of help and care, but who are still able to function independently.

Since January, 1970, Swope Ridge has provided the following outpatient services to the community:

Physical therapy, including speech and inhalation therapy.
Occupational therapy.
Diversional activities.

Outpatient services are available every day of the week and to all income levels. Referrals are solicited from private physicians, general hospitals, state mental hospitals, Department of Public Welfare, religious organizations, private social agencies, and neighbors, relatives and friends of the potential patients.

The difference between this and other outpatient clinics is that the outpatients (community residents) and in-patients (nursing home residents) will receive treatment at the same time, in the same place. In other words, the services are integrated with those provided to residents of the Home.

The purpose of this plan is two-fold: 1) to provide outpatient community services in a non-regimented manner; and 2) to provide residents with further personal contact with the outside community.

It is hoped that this innovative programing will have a beneficial effect on the residents and outpatients alike. The activities program will develop as needs change and the demand grows.

FUTURE THRUSTS—A HEALTH COMPLEX FOR THE ELDERLY

Swope Ridge has accomplished much more than the majority of nursing homes throughout the Nation, both in terms of rehabilitating and treating mentally impaired residents and in reaching out to provide treatment to elderly individuals living in the community.

But the professional staff and administrators are not satisfied.

An outpatient clinic operating from this 145-bed facility will serve only handfuls of older persons when a far greater need exists. Moreover, only 1,024 nursing home beds in this city meet U.S. Public Health Service standards. The need is for 3,879.[15]

> **Swope Ridge is planning the development of a Health Care Complex which will provide several levels of comprehensive care to the elderly, including: a facility to house the "well" aged, who need a semi-protective living arrangement; a building for the mentally-impaired elderly, which will offer specialized care and treatment; another facility for the chronically ill, long-term patients; and finally, Home Care for those individuals who wish (and are still able) to remain in their own homes, but who need some help and care.**

Housing for the "well" elderly within the Swope Ridge Complex will consist of cottages for couples and efficiency or one-bedroom apartments for those who are alone.

All of the services currently provided at Swope Ridge Nursing Home will be available to residents of the Health Care Complex. Some additional services [16] include:

—Outpatient Therapy and Care, to be provided on a much larger scale than presently available at the Home.

—A Day Care Center,[17] which will provide all services and activities available at the Complex, to elderly persons throughout the community, on a regular or occasional basis. Individuals will be welcome at the Day Care Center from one to five days a week, arriving in the morning and returning to their homes in the evening.

—A Home Health Care Program. This program has already begun at the nursing home, in cooperation with the Visiting Nurses Association and Catholic Charities. If a patient receiving care from these agencies indicates a need for physical therapy, occupational therapy or speech therapy, one of the facility's Specialists is sent to aid the patient and to instruct the Visiting Nurse or Home Health Aide. Swope Ridge decided to offer this program on a small scale in order to test new techniques of care, determine the greatest level of need, and "iron out the wrinkles" before

---

[15] Abstracted from: "Proposal for Swope Ridge Restorative Care Center"—Mr. and Mrs. Albert G. Incani, co-founders of Swope Ridge Nursing Home, 1969. It should be noted that Mrs. Incani is a Registered Nurse and once directed the nursing activities at the Home.

[16] Since the Health Care Complex is still in the planning stage, it should be noted that services may be added, deleted, or changed by the time the Complex is completed.

[17] For a more detailed description of Day Care Center, see Project Study Six: Philadelphia Geriatric Center, p. 99.

completion of the Complex, when the program will be offered to a larger number of community residents.

—Nursing Education. Swope Ridge is affiliated with Avila College of Nursing in Kansas City, Missouri, and cooperates with several other nursing schools in the area. Student nurses from Avila College receive their geriatric nursing training at the Home;[18] students from Penn Valley Community College, Kansas City, St. Margaret Hospital, Kansas City, Kansas, and Independence Sanitarium and Hospital in Independence, Missouri, spend several days of each semester there, observing techniques in the care of chronically ill and mentally impaired elderly. The Missouri Division of Employment (which administers the State's Manpower Training Program for Licensed Practical Nurses) sends student L.P.N.'s to Swope Ridge for clinical experience.

The geriatric nurses' training course is part of the in-service training program at the Home, described earlier. Staff Nurses' aides and Registered Nurses attend this course, as well as student nurses.

These educational programs were instituted in 1969 and will be expanded when the Complex is completed. The Home has contemplated offering a complete course in geriatric nursing to student nurses, nurses' aides and L.P.N.'s, who would also receive clinical experience at Swope Ridge.[19]

The shortage of trained nursing personnel is critical.[20]

The Administrators at Swope Ridge are hopeful that the nursing education to be offered in the new Complex will provide a "pool" of trained nursing personnel for their own use, as well as training geriatric nurses to serve in general hospitals, other nursing homes and related facilities, and the community-at-large. Nursing training provided in an innovative setting such as this can also do much to dispel the stigma attached to aging persons and encourage students to enter the field of geriatric nursing.

The Health Care Complex will house 850 residents, and provide Home Care and/or outpatient treatment to approximately 1000 persons.

A NURSING HOME THAT WANTS TO "DO MORE" IS FACED WITH PROBLEMS

Swope Ridge has traditionally opened its doors to persons of every religious faith, ethnic group, racial background and income level. However, the quality of treatment and care provided here, the range of activities, and the training of nursing and ancillary personnel all cost money. Such innovative care is expensive.

When Missouri went into the title XIX (Medicaid) program, Swope Ridge enthusiastically accepted Medicaid patients. But Medicaid

---

[18] The course is approved by the North Central Association of Colleges and Secondary Schools.

[19] A new program is being developed, in cooperation with the Kansas City Metropolitan Junior College, which will provide a new position to the nursing staff—Certified Unit Leader. This position is designed to better provide for the patients' social and psychological needs; make more efficient use of the skills of the registered nurses; and to provide an opportunity for advancement for those in the lower ranks of the nursing profession.

[20] See "Trends in Long-Term Care", Subcommittee on Long Term Care of the U.S. Senate Special Committee on Aging, July 30, 1969, for testimony related to shortage of nursing personnel, pt. 1, p. 105.

in Missouri pays only $13.50 a day and the Home's cost is approximately $31.00 a day. This means that the nursing home has had to pay the balance of $17.50 for Medicaid patients, out of its own pocket. According to the Executive Director of Swope Ridge, "Charity is wonderful, but you can just do so much and then you start losing money."

Although Swope Ridge still cares for approximately 8–10 such patients, *they have had to stop accepting Medicaid cases, because they simply cannot afford to care for them.*

While the Home has a policy of keeping individuals on who have suffered loss of income, they cannot accept Welfare patients (they do accept emergency cases—those who have exhausted every avenue of care and have no place else to go) for the same reason.

Lack of income is in no way related to lack of need (indeed, as has been discussed earlier, poverty and illness among the elderly usually constitute a need for more care) and yet, this excellent facility, which has shown its willingness to care for poor elderly persons, cannot afford to do so.[21]

> **Needless expense on the local, State and Federal level could be spared through the development of comprehensive health care systems for the elderly, according to testimony heard again and again at hearings before the U.S. Senate Special Committee on Aging, within recent years. Expensive hospital beds are increasingly crowded with long-staying patients because there are so few qualified places to which they can be transferred for recuperative care. Operating costs in even the best nursing homes are much less than those in a hospital. The availability of adequate housing, outpatient services and home health care programs would do much to prevent costly and often unnecessary hospitalization of elderly persons. The preventive and rehabilitative benefits to be gained from comprehensive and coordinated health care services has been amply documented. And yet, Swope Ridge has had the plans for its projected Health Care Complex—which would provide just such comprehensive care—on the drawing boards for more than four years, because of the lack of adequate funding.[22]**

Nursing homes of the calibre of Swope Ridge are few and far between. When such facilities make a genuine and concerted effort to affect a change in the delivery systems of health care, and financial support is withheld, other institutions will be discouraged from change—and health costs will continue to rise.

CONCLUSION

From the outside, Swope Ridge appears no different from the thousands of modern nursing home structures that have sprung up across the country within the past decade.

---

[21] What kind of nursing home cares for the indigent elderly? One recent study, Anderson, N. N. and Stone, L. B., "An Investigation of the Differential Characteristics of Proprietary and Non-proprietary Nursing Homes in Minnesota," finds that: "nursing homes with high concentrations of welfare patients had less space, fewer bathrooms, less staff and fewer opportunities for patients to participate in social and psychological programs."

[22] Swope Ridge was granted an insurance loan in 1970, which provided the necessary funding. Projected completion date is late 1972.

Once inside, the visitor to this facility may be surprised by the elderly "tour guide" who offers to show him her "home." Perhaps they will stop at the gift nook to purchase a handicrafted object made by patients, and go on to the social center, to see patients in wheelchairs, enjoying a "dance class," and in yet another section of the center, hear elderly patients engaged in a heated discussion of current events. If they look out into the patio, they may see the Garden Club, actively planting and cutting a variety of plants and flowers. Upon leaving the home, the visitor may pass a group of animated elderly persons, dressed in their "Sunday best" and ready for an evenings' outing at a nearby nightclub.

Can these people really be chronically ill, disabled, mentally impaired and among the oldest of the aging population? Indeed they are, but this is no ordinary nursing home.

Here, elderly residents are provided with life-giving, therapeutic care, and psycho-social activities so that they may look forward to life.

Swope Ridge is truly a pioneer in promoting good mental and physical health for the elderly. Such facilities are rare, but there is encouraging evidence that others are joining Swope Ridge in offering the kind of treatment and care that does not allow patients to sit passively and wait for death.

The innovative programs being carried out at Swope Ridge have direct meaning for the disabled, chronically ill and mentally impaired elderly; not only for the ¾ million [23] who reside in nursing homes today, but for the thousands more who will enter such facilities as the older population grows.

[23] Figures abstracted from "Organizing Rehabilitation Services for the Elderly"—Leonard E. Gottesman, Ph.D., University of Michigan-Wayne State University, Institute of Gerontology, October, 1969.

PROJECT STUDY SIX

PHILADELPHIA GERIATRIC CENTER—PLANS FOR THE COMPREHENSIVE APPROACH

Mentally ill aged individuals, as this report has stressed, do not fall neatly into institutional categories. Many can and should stay at home, if provided with supportive services. Many can live "independently" in apartments, if the apartments provide for some emergency medical services and if they have ready access to hospital facilities. And many can stay in a home for the aged or nursing home, rather than a State hospital, but only if such facilities offer therapeutic programs and can draw upon personnel usually found in a hospital.

How can all these needs be met? At the Philadelphia Geriatric Center, all the combinations suggested above are available in one city block. These include a hospital; The Home for the Jewish Aged, which was the parent institution; York House North and York House South, two residential apartment buildings; the Gerontological Research Institute; several small unit intermediate boarding facilities; and, in the planning stages, The Weiss Institute for the Mentally Impaired Aged, the first facility of its kind in the Nation. The Center will also establish shortly, a Day Care Center for elderly persons in another part of the city.

The Center is located in a major metropolis and houses almost 900 residents, who represent all health segments of the geriatric population, from the comparatively "well" aged to the most severely mentally and physically impaired.

INNOVATIONS:

1. THE WEISS INSTITUTE: WHICH WILL BE THE FIRST FACILITY IN THE NATION TO OFFER COMPREHENSIVE CARE AND TREATMENT SPECIFICALLY TO THE MENTALLY ILL AGED.
2. REGISTERED NURSES ON DUTY IN EACH OF THE RESIDENTIAL APARTMENT BUILDINGS FULL TIME, WITH A HOUSE PHYSICIAN WHO PROVIDES OFFICE CARE AND MEDICATION TO THE TENANTS.
3. SPECIAL SERVICES FOR MENTALLY IMPAIRED TENANTS AVAILABLE IN RESIDENTIAL APARTMENT BUILDINGS FULL TIME.
4. MEDICAL, PSYCHIATRIC AND RECREATIONAL SERVICES AT THE HOME AND HOSPITAL AVAILABLE TO ALL RESIDENTS OF THE CENTER COMPLEX AT NO EXTRA CHARGE.

5. GERIATRIC DAY CARE CENTER TO BE ESTABLISHED IN ANOTHER AREA OF THE CITY, TO PROVIDE DAY CARE AND TREATMENT OF MENTALLY IMPAIRED ELDERLY, ALONG WITH DIAGNOSTIC AND EVALUATIVE SERVICES.

A "GERIATRIC COMMUNITY" AND HOW IT GREW

The existence of alternatives within a predominantly residential complex for the elderly provides unique strengths and striking results. The philosophy behind the development of the services available within the Philadelphia Geriatric Center is:

> **"There is no 'best plan' for caring for the elderly. There is only the most appropriate plan for the specific individual with his unique set of personal, medical and social requirements."** [1]

But, the philosophy developed as the buildings were added. Thus, it may be said that the evolution of this "geriatric community" had the following steps:

A. *The well aged find a home.*—The Home for the Jewish Aged opened in 1952. From the beginning, the administrators worked to create an atmosphere wherein—the residents' rooms, their personal grooming and dress, the range of activities from which they could choose—all permitted expression of their own personal life-styles. And further, the administrators worked to convey to the residents that The Home for the Jewish Aged was truly their "home" and not an institution where they had been "put away."

Medical and nursing services were provided in the Home, along with an array of rehabilitative programs, to assure the residents' continued mental and physical well-being.[2]

B. *A hospital is added.*—The administrators had become aware of the need for a treatment center within the Home, to provide immediate, acute medical care to residents, so that they would receive expert care from specially trained personnel. Therefore, in 1955 an 84-bed acute hospital was built onto the Home and the name was changed to read, The Home and Hospital for the Jewish Aged.[3]

At the Home and Hospital, the payment fee covers room and board, nursing service, drugs, recreational activities and all social services.

---

[1] In Brody, E. M., ACSW—"The Mentally-Impaired Aged Patient—A Socio-Medical Problem"—*Clinical Medicine*, June 1968. Mrs. Brody is Director of Social Work at the Philadelphia Geriatric Center. The Committee is grateful for her help in preparing this chapter.

[2] Upon admission to the Home, each resident is given a complete medical and psychiatric examination and thereafter receives periodic check-ups from the physician who has been assigned to him as his "family doctor." In addition, the residents are provided with the services of consulting specialists, which include psychiatrists, physiatrist (physical medicine), dentists, an optometrist and a podiatrist, all under the direction of the Home's medical director. Several residence areas within the Home offer varying degrees of personal and nursing care, and residents are assigned to those areas in which best suit their individual needs. Nursing service is available 24 hours a day.

The Department of Physical Medicine offers a rehabilitative therapy program, based on a physiatrist's recommendations. The recreational and occupational therapy programs are designed to be for both individual and group participation. The group activities include birthday parties, current movies, bingo games, trips and picnics, a resident club, a service club, current events and music appreciation discussion groups, ceramics, painting, weaving, knitting, sewing, rug-making, basic English and creative writing classes (the Creative Writing Class edits the Home bulletin). A music therapist involves residents in singing and other forms of music participation. A number of the above activities are brought to the living areas for residents who could not otherwise participate.

[3] The hospital is fully accredited by the Joint Commission on Accreditation of Hospitals. Those medical facilities not available, such as surgery, are provided at the nearby Albert Einstein Medical College.

The actual payment and method of payment is determined in accordance with the resources of each applicant.[4]

C. *An institution becomes a "community".*—The Home and Hospital for the Jewish Aged had evolved into an *"institutional community"* where residents and patients alike were provided with a wide range of medical, psychiatric and rehabilitative care. But there was no provision for older persons who need independent housing with some help and care. It was decided, therefore, to build, in the same city block as the Home and Hospital, independent apartments for the "well" elderly, which would provide some nursing and medical services.[5] York House North and York House South, residential apartment buildings, were opened in 1960 and 1965 respectively. The two buildings house 396 individuals in efficiency apartments and 60 couples in one-bedroom apartments.[6] Tenants range in age from 64 to 98 with a median age of 75 years. "Row houses," across the street from the residential complex have been purchased and converted into small unit boarding arrangements, where individuals may live while awaiting admission to the York Houses in intermediate boarding arrangements.

The individuals housed in the York Houses and boarding houses are indeed, living independently. They are not "patients" or "residents" of an institution. But, unlike other residential housing for Senior Citizens, these facilities offer the added security of knowing that a physician and/or nurse is always available.

If necessary, there is easy access to dentists, podiatrists and physical therapists; and a wide range of social and recreational programs are available from which tenants may choose—all within one city block. All of these services—along with the independence that comes from a close proximity to public transportation, shops, banks, movie theaters and markets—contributes to continued mental and physical health and well being.

---

[4] The Committee asked Mr. Arthur Waldman, executive vice president at Philadelphia Geriatric Center, to comment on the effect of Medicare on the Home and Hospital. His remarks follow:

"*Medicare has helped:*

"1. It enabled us to increase our full-time medical services.

"2. We were able to expand physio-therapy personnel and program.

"3. We were able to add Inhalation therapy.

"In short, Medicare enabled us to raise the overall quality of *medical* care.

"Medicare has not helped to finance long-term non-acute care. That is, long-term care is needed primarily by the oldest stratum of the aged population who often need care continuing well-beyond the 100 days of extended care provided by Medicare. In Pennsylvania, long-term care is funded through the public assistance nursing home care program. The maximum grant is $335 monthly (plus $5 spending money for the patient). Since our actual cost is $510 monthly and 80% of our people are public assistance recipients, we are running a big deficit. I know of at least two other voluntary homes in Philadelphia who are threatened with the prospect of closing down. Actually, Medicare in a way made the long-term care situation worse, since proprietary nursing homes understandably prefer the higher-paying ECF patients, thus creating a shortage of public assistance beds. In any event, it is impossible to give good care for $335 monthly, since that figure must carry costs of nursing staff, social service, recreation, etc. as well as room and board."

[5] A house physician is available seven days a week in each apartment building for routine office care and medication. A registered nurse is on duty in both buildings at all times. The tenants have complete access to the medical facilities in the Home and Hospital as needed and they have the choice of transferring to the Home and Hospital when they are no longer able to function independently. An intensive care floor in the York House South building, houses 33 persons who need more protective care than is provided else where in the apartment buildings, but not the extensive care of the Home. A complete nursing staff is assigned to this floor.

Specialized care is available for mentally impaired tenants. Upon recognition of any symptoms of mental impairment, the house physician recommends that the tenant's family call in a psychiatrist for diagnosis, recommendation and/or treatment—medication prescribed by the psychiatrist is administered by staff nurses directly, rather than leaving instructions for the tenant—meals are delivered to the tenant for a period of time and extra housekeeping services are provided—companions or nurses, friendly visitors, are permitted to stay with the tenant to provide adequate supervision—regular psychiatric consultations are available to the administrators of the apartments to aid in dealing with troubled tenants. As long as the tenant does not constitute a threat to himself or others, he may remain, but once his behavior becomes unacceptable, he is asked to move to one of the other Center facilities where he will receive more intensive treatment.

[6] The waiting list for the York Houses now exceeds almost 600.

With the establishment of the residential apartments and boarding houses, the Home and Hospital became a self-contained "geriatric community." [7] At this point, the "community" was ready for another step forward.

THE NEXT STEP—THE GERIATRIC DAY CARE CENTER [8]

Plans are underway for a Geriatric Day Care Center, to be located in the Northeastern part of the city, where large numbers of elderly persons reside.

Through arrangements with the Community Mental Health Center and its Base Service Unit,[9] the Day Care Center will serve 40 mentally impaired and mentally retarded aged persons (65 and over) per day, who are not in need of care in an acute general or psychiatric hospital.[10]

The Center will provide service to those elderly individuals who may have been discharged from mental institutions (or whose discharge is being planned), those who are receiving community based outpatient services, and those who are living in the community alone or with relatives and have not previously had mental health services.[11]

The staff at Philadelphia Geriatric Center, involved in the planning of the Day Care Center, anticipate that the care and treatment received by the patients will prevent and reduce repeated admissions to psychiatric facilities.[12]

In order to avoid the mistakes made by other out-patient services to the elderly, such as health centers, hospital out-patient clinics, recreation centers and social agencies,[13] planning calls for a bus and bus drivers to be hired, so that patients can be picked up at their homes in the morning, and returned at the end of the day.

Patients participating in the Geriatric Day Care Center Program will be provided with a wide range of therapeutic activities, five days a week. Some of the activities planned, include:

—Medical and psychiatric evaluation and treatment.[14]

---

[7] The Gerontological Research Institute is still another component in this "geriatric community." Biological and biochemical research is conducted here by a complete medical staff, along with biochemists and psychologists, in laboratories fully equipped for animal and human studies. The Behavioral Science Section of the Institute conducts social and psychological research and is staffed by social workers, psychologists, sociologists and an anthropologist. The Institute is engaged in 5 Federally funded studies, one supported by a private foundation and six that are supported by the Philadelphia Geriatric Center.

[8] This program may be hampered by a lack of funding, caused by Pennsylvania's recent cutbacks in Medicaid and Mental Retardation funds. The site has been selected, staff has been planned for, and the program itself is in readiness. The Philadelphia Geriatric Center has informed the Committee that they are hopeful the funds will be forthcoming shortly, but that some of the plans described in this section may be altered by the time the Center actually opens.

[9] Primary referrals to the Day Center will come from the Base Service Unit. When the Center accepts a patient from the Service Unit, it will provide Unit with periodic service reports and maintenance records. The Day Care Center will refer patients back to the Base Service Unit when additional or alternate services are required. Referrals will also be made by the usual social and medical agencies, families, physicians and other voluntary agencies.

[10] Acute medical condition requiring hospital service or behavior dangerous to self or others.

[11] Information abstracted from "Proposal for the Establishment of Geriatric Day Care Center for Mentally Impaired and Mentally Retarded"—Bernard Liebowitz, Assistant Executive Director, Philadelphia Geriatric Center.

[12] Cited in footnote 11.

[13] In "Proposal for the Establishment of Geriatric Day Care Center for Mentally Impaired and Mentally Retarded", Mr. Bernard Liebowitz noted that "Practitioners in all fields (medicine, family social agencies, public assistance agencies, hospital clinics, etc.) have noted the difficulties in getting the aged person physically to the point of service-delivery."

[14] The responsibility for overall management of the patient will remain with the Base Service Unit of the Mental Health Center, or the family physician. The Center staff will arrange the necessary additional examinations and studies and report findings to the patient's physician. They will work together to implement treatment which can be carried out at the Day Center (administering of medication, special diets, prescriptions for occupational therapy, recreational therapy and physical therapy).

—Emergency medical care, through arrangement with a nearby hospital.
—Rehabilitation and re-training services to aid the patients in improved self-care (feeding, dressing, grooming, and toileting) and performance of simple tasks required for continued community living (telephoning, shopping, preparing meals and marketing.)
—Nursing care.
—Physiotherapy (upon prescription from physician or Community Mental Health Center Base Service Unit) to improve mobility.
—Individual and group psychiatric social work services to patients and to family members. The family will participate, in order to understand and to cope with problems that arise with mentally impaired and retarded elderly persons.
—Recreational and occupational therapy (upon medical prescription.)
—Sheltered workshop.
—Recreational activities (crafts, painting, knitting, outings, cooking, weaving, ceramics, music, dancing, and choral groups) to improve social behavior and re-establish impaired abilities to communicate with others.

The therapeutic services listed above will not all be available for every patient. Specific activities will be selected for each patient, taking into consideration his level of mental impairment and his physical disorders. As the Geriatric Day Care Center Program progresses, new techniques will be added. Activities that have proved ineffective will be dropped. In other words, the program will change as the patients' needs change.

The personnel of the Philadelphia Geriatric Center will be responsible for hiring and training the staff of the Geriatric Day Care Center. They will also be available for on-going consultations with the Day Care Center staff.

The staff of the Center will include an administrator, a psychiatrist, physician, psychologist and clinical psychological assistant, social workers, recreational and occupational therapists, mental health aides, psychiatric registered nurse and nursing staff, physiotherapist, dietician, bus drivers, housekeeper, and clerical workers.

As shown earlier, the Harlem Geriatric Group Therapy Project—limited to group discussions and activities for one hour, one night a week (per group)—has had dramatic results with older persons suffering from mental disorders. A day care program which provides medical and psychiatric therapy *all day for five days a week*, could go much further. It can help older individuals remain in their own homes, provide isolated persons with social relationships keep families together, and possibly pave the way toward a real system of coordinated health care for the elderly.

THE BIGGEST STEP OF ALL—THE WEISS INSTITUTE

Innovative as the pioneering steps taken by the Philadelphia Geriatric Center have been, the staff of the Center is well aware that further steps to help mentally-impaired elderly persons can be achieved only

after an authoritative body of information has been gathered on the select problems of these unfortunate individuals. They are, therefore, preparing to embark on a new venture:

—a 120 bed unit in which mentally impaired persons will be systematically studied, cared for, and treated.

Many of the patients will come from other units within the Center complex. Some will come from the community and others will come from mental institutions. The patients will be individuals suffering from all types of mental disorders, ranging from the mildest brain syndrome to the most severe mental illness.

When the Weiss Institute is completed (a two-year completion date is anticipated), it will be the first such facility in the nation: one that is not a nursing home or a psychiatric hospital, but a unit that will deal exclusively with the select problems of the mentally impaired elderly. This new project is an important move forward toward the Center's goal of a truly "comprehensive" approach to the care of the elderly.

An experiment in architectural design.—Perhaps the most innovative aspect of the Weiss Institute will be the structure itself. The building will be five stories tall, consisting of two octagonal wings joined by a middle section. This middle section will be occupied by the medical service facilities.

All windows on the residential floors will have an outside view, and each patient's room will open into a central social and recreational area.

The ground floor will house clinics, examining rooms, laboratories, classrooms, research offices, auditorium and administrative office.

Among the architectural devices to aid the disoriented patients, will be:

—"trail marking" with carpet or tile to mark paths to and from bathrooms or dining rooms.

—tactile coding of handrails leading to bathrooms, dining rooms, and treatment rooms.

—the building will be broken up into relatively small units, housing approximately 19 persons each. The patients will be spared the stress of finding their way through (what seems to be) great distances, and they will be encouraged to move about freely within the unit and to "feel at home."

An experimental treatment program.—The research unit in the new building will be equipped with one-way vision rooms, sound and video monitoring, and research offices on each floor. The research activities will be integrated into the treatment methods used not only in the Weiss Institute, but throughout the Center Complex.

Along with the psychiatric and medical treatment, a wide range of recreational and occupational therapy programs designed for both individual and group participation, will be available to the patients.[15] Among them:

—Sheltered workshop.[16]

—Volunteer and Friendly Visiting Program to keep the patients in touch with the outside world.

---

[15] Many of the activities offered in the Home and Hospital will also be available in the Weiss Institute. But they will only be offered to certain patients, dictated by the level of impairment.

[16] For a detailed description of Sheltered Workshop, see Ypsilanti Milieu Therapy Project, occupational therapy, p. 33.

—Dancing, singing, and other group activities.
—Speech therapy for patients suffering from Aphasia [17] and other speech defects.

Varied outpatient programs will also be available at the Weiss Institute. The usual evaluation and diagnosis available in other outpatient clinics will be provided, as well as the following experimental programs:

—Day Care program (similar to the Geriatric Day Care Center)
—Home Visit and Evaluation Program
—A "Vacation Plan" providing temporary care for short periods to those aged persons living in the community with their families.[18]

Outpatient programs such as these can insure appropriate placement and treatment, if institutionalization becomes necessary.

Plans call for a complete professional staff to care for the 120 patients housed in the Weiss Institute:

—two resident psychiatrists
—one or more general physicians or internists
—a physiatrist
—complete nursing staff
—recreational and occupational therapists
—complete department of social work

Upon completion of the Weiss Institute, the Philadelphia Geriatric Center will have taken perhaps the biggest step of all toward realizing their basic philosophy of providing, "the most appropriate plan for the specific individual with his unique set of personal, medical and social requirements." [19]

That philosophy has been strengthened with each new addition to the Center complex, with each new service offered, and with each new treatment technique that "worked" for the patients.

But further steps are needed. Problems remain which must be solved before the Philadelphia Geriatric Center can provide a true system of comprehensive care to its residents and to the surrounding community.

SUCCESS BRINGS SERIOUS PROBLEMS TO LIGHT

The Philadelphia Geriatric Center receives four times as many applications as they can take per year. There are, as of this writing, 300 persons on the waiting list for the Home for the Jewish Aged. There are almost 600 persons on the waiting list for the residential apartment buildings (York Houses).

Fortunately, the Center can offer supplemental care to these individuals—psychiatric counseling, and referral to another more appropriate facility, if necessary. But Philadelphia Geriatric Center is one of a kind. Many excellent facilities for the aged across the Nation are

---

[17] See glossary, p. 183, for description of Aphasia and other speech defects.

[18] A number of beds will be set aside for this purpose. The family does not often (sometimes never) get time off from the all-consuming duties involved in caring for an elderly parent who is mentally impaired, although they may have no wish to institutionalize him. The emotional stress created by this situation among family members is well known to geriatric social caseworkers and clinicians. A shelter such as this can do much to alleviate family stress and also serve as a diagnostic tool, with a view to ascertaining what further treatment may be helpful.

[19] See footnote 1, p. 100.

forced to turn away applicants without any referral service, and their "screening" interview is limited to the initial telephone request because of lack of staff and funds.

Requests for admission to homes for the aged and similar facilities usually occur at a time of crisis, when there is often no other alternative, such as remaining at home. The family (when there is one) has waited too long to seek help for their aged parent or relative, because of guilt feelings, the expense involved, or ignorance of the channels open to them to secure aid.

What happens to these unfortunate persons, who may not need to be institutionalized, but who are in desperate need of treatment and care?

To answer this question, the Department of Social Work at the Philadelphia Geriatric Center recently completed a follow-up study of 100 applicants and non-applicants (those who did not file an application after the initial interview) to the Home for the Jewish Aged, one year after the initial interview with the Social Worker at the Home. Mean age for both groups was 78. Three-quarters of each group reported income of *less than $120 monthly*.

A number of the applicants were helped by the social workers at Philadelphia Geriatric Center to find adequate alternative care solutions.

However, the lack of available supportive resources in the community created much emotional, physical and financial stress for many of the applicants and their families during the interim period.

> CASE STUDY: Mr. B. had never wanted to institutionalize his wife. At the end of his financial, emotional and physical resources, he finally applied for admission to the Home for the Jewish Aged. Mrs. B., suffering from chronic brain syndrome, had deteriorated to the point where she could not be left unsupervised for even a few minutes. She started fires, wandered out and got lost, needed total care for feeding, dressing, etc. The local family agency supplied a domestic for two half-days weekly, but the brief respite was not enough to relieve Mr. B's exhaustion and nervous strain. Space was not available at the Home. Mr. B. was unable to cope with the lengthy procedures necessary to establish eligibility for a nursing grant and bewildered by the fact that such eligibility did not ensure admission to a nursing home. The Home's social worker drove him to the public assistance office, helped extricate him from the requirement that nursing OAA care grant could not be authorized until admission had taken place, and finally, helped Mr. B. place his wife in another voluntary home in a location almost impossible for Mr. B. to visit. In order to establish his wife's eligibility for public assistance, Mr. B. was compelled to dispose of his last resource, the automobile which would have permitted him to visit his wife.[20]

The Philadelphia Geriatric Center is a unique institution which serves one segment of the aging population of one city in the United States. It is safe to assume that elderly persons experience the same

[20] Case abstracted from: Brody, E. M., ACSW—*Follow-up Study of Applicants and Non-Applicants to a Voluntary Home.*—"The Gerontologist," Vol. 9, No. 3, Autumn 1969.

frustrations all across the Nation. The Committee has spoken with administrators of Homes for the Aged in other cities. Their reports were much the same as that of the Philadelphia Geriatric Center.

CONCLUSION

INSTITUTIONS VERSUS COMMUNITY BASED PROGRAMS—BOTH ARE NEEDED

The Committee's study of this institution and its community-related programs serve to demonstrate that something can, and is being done for elderly persons suffering from mental disorders. But it also illustrates the variety and magnitude of problems presented to an agency (The Philadelphia Geriatric Center) whose goal it is to provide comprehensive mental health services to an increasingly large group of older persons.

The incidence of mental disorder among the elderly is high, and usually accompanied by physical illness. The individuals who suffer from mental and/or physical impairment are for the most part older, sicker and poorer than the general aging population; and they frequently need to live in an institutional setting.

The very nature of this population and the statistical facts regarding their numbers dictate that we put aside the arguments about the evils and virtues of institutional versus community based programs. The success of the Philadelphia Geriatric Center indicates that both have a place. It has also illustrated that the aged can and do respond to physical and social therapeutic efforts. But, in order for the lay public as well as the professional community to accept the fact that such efforts can be successful, a re-definition of therapeutic gain is needed.

> **The expectations which are indices of improvement with other age groups: discharge from hospital to community, re-employment, are not always applicable to the elderly. When an aged person moves from wheelchair to walker, from apathy to a minimal level of social participation, from the total disregard of grooming to simple tasks; these, too, are legitimate therapeutic achievements.[21]**

The Philadelphia Geriatric Center has come a long way in the twenty years since the Home for the Jewish Aged opened its doors. The growth of this institution, step by step, gradually expanding its services until it became a self-contained "geriatric community"; and then reaching out to offer help and care to the community at large, could serve as an example to other institutions for the elderly across the Nation.

If the example set by the Philadelphia Geriatric Center is acted upon, we may yet see the day when comprehensive care for the elderly is a reality.

SOME OTHER PROGRAMS WORTHY OF NOTE

The project studies discussed at length in Part Four of this Report were selected to illustrate the diversity of treatment methods and

[21] Cited in: Brody, E. M., ACSW—"The Mentally-Impaired Aged Patient—A Socio-Medical Problem" *Clinical Medicine*—Vol. 75, June 1968, P. 57.

community facilities which are being developed across the country in an attempt to meet the multiple needs of the mentally and physically ill elderly population. Many other good institutional facilities emphasize treatment and rehabilitation rather than "custodial" care, along with a variety of community based services, all of which provide physicians, psychiatrists, and social workers with a wider range of therapies from which to select in planning individualized programs of care for elderly persons who suffer from chronic physical ailments, often in combination with mental disorders.

The community and professional concern about the mentally ill elderly reflects the growing conviction that something can be done; that the mentally ill elderly are not "superfluous people" to be relegated to facilities where custodial care is provided while they mark time until death.

Here, briefly described, are some other programs that are worthy of consideration:

State Hospital Programs

Napa State Hospital[1]—Located in the North bay region of California, this State hospital began its resocialization program for elderly patients during 1959, when the large number of older patients in the hospital focussed attention on the need to increase treatment efforts in the hope that these patients might be released through intensified treatment and preparation for life in the outside community.

In order to be eligible for this program, patients must be 65 years of age or older, and not showing major symptoms of psychosis. Approximately three-quarters of the patients first selected were schizophrenics who had aged in the hospital. However, as the program grew, newly admitted elderly patients were also selected if they showed evidence of being able to respond to the treatment method.

A screening team—consisting of a psychiatrist, a physician, and a social worker—goes into the geriatric wards and talks with nurses, attendants, and patients, and selects patients eligible for the program, on the basis of intensive psychiatric and physical examinations. The resocialization program designed by Ramona Todd, Ph. D., M.D., is divided into four steps. The patients are placed in a "relocation center" in the hospital. The next step is to build a one-to-one relationship between a patient and a staff member. When the patient begins to respond by showing signs of warmth and friendliness, he is introduced to another patient—usually one who is "weaker"—to help, in order to encourage him to feel worthwhile and needed. After the patient shows that he is capable of being a "friend" to another patient, he begins group resocialization activities (small discussion groups, group therapy and other similar activities). When he is able to hold his own in discussion groups, he is ready for the last step, becoming acquainted with community life. At this point, the group leader begins to involve him in community activities. He re-learns how to use public transportation, the library and bank, how to shop, and other activities that will help to assure independence. He is introduced to senior citizens' clubs, church groups and other community activities in which he may wish to participate. The resocialization process takes from *six to eight months, sometimes as long as one*

---

[1] Information from written communication and materials provided by Ramona L. Todd, Ph. D., M.D., Napa State Hospital, Imola, California.

year. When the patient is ready, he is released from the hospital into the most appropriate setting for his particular needs. When the program began, 1,800 patients aged 65 and over were in the hospital. Today there are 750 older patients.

The program has been described as successful, not only in the high percentage of elderly patients released from the hospital, 80 percent, and the low readmission rate, only between 8 and 9 percent percent of these patients return to the hospital—but also in the many reports of happiness and good adjustment in the outside community.

The fact that this is not the only solution to the problems of the mentally ill elderly is recognized by the administrators of the Napa State hospital resocialization program. According to Dr. Todd: "To lump all people past 65 together and generalize as to their needs is folly. There are active, alert, producing people; there are slightly forgetful people; and there are various degrees of organic deficit all the way down to those people completely out of contact with reality and physically unable to move. Where would they make the best adjustment? I believe the answer is apparent. There are many types of facilities needed." [2]

Western State Hospital, Hopkinsville, Kentucky. [3] Three separate and well-defined methods of attacking the problem of mental illness among the elderly are in use. The Comprehensive Community Mental Health Center treats those elderly patients who can be maintained in their own homes (hospital psychiatric staff is also on duty at the Community Mental Health Center) or in other community protective care settings, in the short-term geriatric intensive treatment unit at the hospital, (for those patients with acute conditions who should be treated in a hospital setting for a short period of time), and the hospital's Community Placement Center, which serves those patients who have aged in the hospital, as well as those with more difficult symptoms who have been allowed to deteriorate in the community. The three programs are distinct in terms of staffing and location, but they often complement each other. Indeed, most elderly mentally ill patients are provided with planning and placement services at the Community Placement Center. [4]

This Center is a separate unit on the hospital grounds, comprising fifty beds in an attractive and homelike setting. Patients reside in the Center for six months and have the benefit of a full-time psychiatrist, registered nurse, licensed practical nurse, social worker, nurses' aides, an occupational therapy aide, and recreation aide. All services at the hospital are available to patients.

The Center staff consults with other ward personnel to designate elderly patients as candidates for the Community Placement Center. These patients are then readied for transfer to the center by the staff on their ward, so that they, in a sense, have a "head start". During their six-month stay in the Center the patients receive medical, physical, and psychological treatment, as well as rehabilitative services, with the purpose of placing the patients in suitable settings in the outside community.

---

[2] In written communication from Ramona L. Todd, Ph. D., M.D., Napa State Hospital, Imola, California, June 5, 1969.

[3] Information provided by T. F. Burke, M.D., Medical Superintendent, Western State Hospital, Hopkinsville, Kentucky.

[4] The Community Placement Center was initially funded through a one-year hospital improvement grant from the National Institute of Mental Health.

The Center engages in intensive screening of community placement facilities, and places patients, according to their individual needs, in three separate types of facility: The Family Care Home, The Personal Care Home; and Nursing Care Homes. All placement facilities selected are approved by the Social Work Department of the Hospital, or licensed by the State Department of Economic Security Division of Licensing and the State Department of Health. After placement, those patients who are capable of engaging in such activties are provided with a Work Placement Program by the Hospital's Vocational Rehabilitation Department. These patients are encouraged to participate in work assignments (aside from normal duties of private housekeeping) in their community living arrangements or in the outside community. The homes are asked to pay for such work. The hospital encourages this type of activity in the hope that eventually it will lead to more independent living or full-time employment.

Western State Hospital has developed a workshop program for the sponsors and operators of Community Placement facilities in the State to help them care more effectively for discharged elderly mental patients. Workshops are conducted from time to time at the Community Placement Center. Personnel from the personal care, family care, and nursing care homes are encouraged to attend. The Center also publishes a monthly newsletter to community placements to keep personnel informed on new rehabilitation and recreation technical services.

Patients released from the Community Placement Center are released to the care of the Comprehensive Community Mental Health Centers in the State, no matter what their living arrangement. In this way, psychiatric treatment and care can be continued after the patient leaves the hospital, until such time as it is determined that he is capable of living independently.

Green Light Program at a State Hospital.—Green Light (a component of the Green Thumb program sponsored by the Farmer's Union under a grant from the U.S. Department of Labor), has traditionally provided older women from rural areas with useful work, and extra income from service activities which help other aging persons in their communities. But in 1969, for the first time, a Green Light program was established in a state hospital as part of the rehabilitation program, A small group of women at Madison State Hospital, Madison, Indiana, were trained and employed in the community—*while still living in the hospital.* [5]

The women may be employed for a 24-hour week earning $1.60 an hour. After discharge, they are assured employment in the community. During the year and a half the program has been in operation, some sixteen women have been "graduated" from the Green Light program, going on to work in the community after discharge as home aides, library assistants, senior aides at Senior Citizen Centers, kitchen aides, and maintenance workers in motels and hotels. The program has been described as successful, but it has moved slowly and can only serve a small number of the female elderly patient population in the hospital. Because of funding limitations, the program can only train six women at a time. Even on this small scale,

[5] Information provided (spoken communication) by Mrs. Caroline Bonadio, Supervisor, Vocational/Industrial Therapy, Madison State Hospital, Madison, Indiana.

the Green Light program has illustrated the value of training and providing valid employment for persons being discharged from a state hospital, *most of whom had been in the hospital for as long as 20–30 years.*

GENERAL HOSPITAL PROGRAMS

Coney Island Hospital Geriatric Multi-Services Unit.[6]—In recent years, Coney Island has deteriorated to the point where it has been designated as one of the eleven Brooklyn poverty areas by the Federal government. For years, the area has had a high concentration of older persons (in 1960, 15.7 percent of the population was 65 and over, as compared with the Brooklyn rate of 9.9 percent—50 percent higher), and there is evidence that this has increased due to the development of public housing and special housing for the elderly. Older residents of urban poverty areas are also low-income persons, who are threatened by the high incidence of crime, drug addiction, and alcoholism in these areas. They have become increasingly isolated from the community, fearful of assault and bodily harm.

Coney Island Hospital is the only municipal hospital serving the southern part of Brooklyn, which includes Bay Ridge, Gravesend, Bensonhurst, Midwood-Flatlands, Sheepshead Bay, and Coney Island. The hospital has a bed capacity of 750, which includes 100 beds for chronic care.

The Psychiatric Division staff of the hospital has long been interested in the social and health problems of older individuals as seen in the various departments of the general hospital, outpatient clinics, and in the community. There was increasing concern about the lack of coordinated services for the elderly and the need for a cooperative program, including other interested agencies to serve this population group.

In June 1969, aided by a 3½-year grant from the N.Y. State Department of Mental Hygiene the Psychiatry Services Geriatric Multi-Services Unit was established with the objectives of: identifying elderly persons with emotional and behavioral problems in the hospital and in the community; offering treatment, consultation, and referral to other agencies; utilizing the full range of general hospital services, including psychiatric; determining the amount and range of facilities and services available from public and private agencies; providing consultation, education and screening services to other interested agencies; and ascertaining gaps in service, in order to promote establishment of additional resources. The Unit is staffed with a Public Health Nurse, a psychiatrist (who works 14 hours a week), an internist, two community workers, a social worker, and a secretary.

The unit occupies two large rooms in the John E. Hammett Pavilion of Coney Island Hospital. Rooms are subdivided to provide individual offices for staff, allowing a large area to be utilized for group treatment, activity programs, and conferences.

The Unit has been at work for a year and a half. Thus far, it has accomplished a number of its objectives. The geriatric team has served as a specialized treatment resource for the hospital's Adult Psychiatry Clinic, General Hospital Liaison Service, Day Treatment Center staffs, along with other general hospital and community services. Patients seen in these services have been referred

[6] Information provided by Leslie Fine, M.D., Associate Chief, Psychiatry Services, Coney Island Hospital, Brooklyn, N.Y.

to the geriatric team for home visits and group or individual psychiatric treatment. The team also refers inpatients and community residents to psychiatric and general hospital departments for treatment and care. The team has instituted a monthly seminar with Coney Island Hospital Medical Social Service staff who deal with geriatric patients. Case consultation is provided, along with discussion of organic and chronic brain syndromes, depression among elderly patients, reaction to illness, and problems of dealing with elderly patients.

Unit Community Workers (similar to the Mental Health Aides at the Harlem Hospital Geriatric Outpatient Clinic) with the Public Health Nurse, attended remotivation therapy (group discussions) training program at Kings Park State Hospital. They have begun a remotivation therapy group in the Extended Care Facility at Coney Island Hospital. Nursing personnel are being also taught remotivation techniques for patients on the Physical Medicine and Rehabilitation Service, and the Extended Care Facility.

A geriatric internist has organized a consultation service for elderly patients first encountered in the hospital emergency room. Such patients do not always require admission to a general hospital but they do require extensive medical or psycho-social evaluation which cannot be conveniently done in the outpatient clinics over an extended period of time. Beds have been made available in the extended care facility of the hospital, for such patients, who are allowed a "boarding" situation for a limited time, pending placement in nursing homes. This practice has permitted relatives to be contacted and involved in patient care and placement, and it has also created an opportunity to care for elderly patients until services such as home care, visiting nurses, homemaking services, volunteers, can be obtained, enabling the patients to return to the community. The "boarding" of these patients has also presented the Unit staff with the opportunity to provide a trial of medical treatment or psychotherapeutic medication to determine whether such patients could maintain themselves in the community. Previously, these patients would have been refused admission to the general hospital, or would be transferred to Kings County Hospital Psychiatric Service, where they would frequently be refused admission.

The geriatric team has made home visits, on referral by the hospital's Medical Social Service, to assess the patient's environment. The team has worked closely with other community agencies to assure that continuted maintenance in the home is possible. A therapeutic activity (group therapy) group of some 12 elderly patients has regular weekly meetings. The patients were referred by the hospital's Adult Psychiatry Services and other Community agencies.

The geriatric team participates in a series of educational activities intended to acquaint the general hospital staff with the mental health problems of the elderly patients. A panel discussion—led by the team internist, psychiatrist and the hospital Chiefs of Medicine, Extended Care and Neurology—has been conducted for the hospital staff and attending staff on "Organic Mental Sydromes." Soon after the number of psychiatric consultations on elderly patients in the general hospital increased significantly. A number of lectures on "Organic Mental Syndromes" have been presented to community physicians, as well as hospital staff. The geriatric team has implemented a nursing education program to upgrade the performance of the nurses aides

at the Coney Island Hospital. Two all-day nursing workshops have been conducted in the hospital on "Attitudes on Aging" by the team's Public Health Nurse.

The unit has instituted the first socialization group for elderly blind patients in a general hospital in New York City. The team provides space and recruits group members from within and without the hospital facilities, bringing in blind community residents.

The group meets weekly, offering recreation, socialization, and counseling services, it also coordinates referrals to other agencies for special services (such as visual screening in Sr. Centers, cane walking, braille reading, vocational training). In addition, selected group members may attend the VCSB's (Vacation & Community Services for the Blind) summer camp in Spring Valley N.Y. Community Workers from the team have recruited college volunteers to assist with this program. A recreational aide training program has been established by the geriatric team. It is administered and supervised by New York University. The program consists of three teams of 10 trainees each. They work with supervisors and with chronic care patients in the Extended Care Facility and Rehabilitation Medicine wards of the hospital. This has expanded the recreation services for chronic patients. Such services have been inadequate in the past.

The Unit psychiatrist served as a consultant to the Brighton YMHA Nutrition Program. In that program 130 elderly persons received hot lunches five days a week and were also enrolled in the YWHA-YMHA social and recreational activities. Some participants were seen by the psychiatrist at the "Y", and others were referred to the general hospital or psychiatric services for more extensive evaluation and/or treatment. This nutrition program terminated on June 30, 1970, but elderly participants continued attending the "Y" and the psychiatrist has continued to consult with that agency.

The geriatric team also helped to promote a meeting attended by representatives from several departments within the general hospital—as well as the City Department of Social Service and Catholic Charities—to plan and organize a telephone reassurance program, staffed and organized by social workers from the senior citizens centers of the Department of Social Services. Some elderly members of the Centers will regularly telephone isolated older people living alone on public assistance who desparately need contact with other people.

A number of workshops and lectures have been presented by the geriatric team to homes for the aged and housing projects for the elderly in the area. The geriatric unit has also been instrumental in organizing a Subcommittee on Aging of the Professional Services Advisory Committee in Coney Island. This multi-agency, umbrella organization promotes better health, educational and social services for residents in the area, and its members are bringing community pressure to bear on the Department of Social Services of the City of New York to augment local services to the aged.

Now beginning its 2nd year, this project has had the "growing pains" inherent in any new and innovative program, including a major problem of recruiting the psychiatrist. A number of interested and qualified psychiatrists who considered joining the program refused because they felt that the position should be full time. The Geriatric Unit concurs with this assessment and has recommended that provisions be made for a full-time psychiatrist to act as "psychiatric team leader."

Statewide Programs

Restoration Centers, Pennsylvania.[7]—In June 1964, the Pennsylvania State General Assembly passed legislation to establish geriatric centers for elderly patients from state hospitals who no longer needed intensive psychiatric care. The first center was immediately established in a building on the grounds of a state hospital, and in late 1965, the first 200 elderly patients were transferred to a building on the grounds of a state tuberculosis sanitarium. The sanitarium was shortly phased out and the entire facility became the South Mountain Geriatric Center, with a bed capacity of 1,000. The Center, located on a mountaintop five miles from the main highway, provides the patients with medical, surgical, (52 of the first 443 patients admitted needed surgery), psychiatric, social and rehabilitative services and care. The Center utilizes remotivation therapy—small discussion groups—similar to the treatment method at Napa State Hospital, as well as occupational therapy and other socialization activities, to prepare patients for life in the outside community.

Patients are free to come and go on the grounds of the Center as they please and are encouraged to be as independent as possible. An effort is made to explain any new developments in the rehabilitation program to the patients, as well as an estimate of how long they may expect to stay at South Mountain (many of these persons have been herded from one ward to another, or one institution to another, for years, with no explanation). One drawback of the South Mountain Restoration Center is its isolation from the general community. Mr. Elias S. Cohen, a former Commissioner of Family Services in the Pennsylvania Department of Public Welfare, remarked: "Its remoteness hampers the recruitment of capable staff and imposes severe disadvantages on the vital discharge and placement program." However, more than 70 percent of the patients admitted to the Center have responded to treatment, and more than 300 have returned to community living. Patients are discharged to boarding or foster homes, retirement homes, or veterans centers. If a patient becomes ill after release, the Center arranges transfer to a hospital or nursing home for as long as such care is required.

A second Geriatric Center was established in Pittsburgh three years ago in another converted tuberculosis hospital. Named the Western Restoration Center, this facility has a 97-bed capacity and provides both outpatient and short-term inpatient care. Patients come here directly from the community rather than from a state mental hospital, thus alleviating the need for long-term commitment for many older persons.

Within the next 10 years, Pennsylvania is expected to develop a statewide system of eleven such Restoration Centers, with a total capacity of over 3,000 beds.

Programs in Other Institutions

Sunny Acres Convalescent Hospital.[8]—Many good nursing homes across the Nation provide better than adequate care for elderly pa-

[7] Information gathered from "Pennsylvania Rehabilitates Older Mental Patients" AGING, August-September 1968; "The Restorative Potential of Elderly Long-Term Residents of Mental Hospitals" by Elias S. Cohen, M.P.A. and Alfred C. Kraft, M.D., The Gerontologist, Volume 8, Number 4, Winter 1968; and from summaries of the Western Restoration Center by Stanley E. Snyder, ACSW (Administrator) and South Mountain Center by Louise Schwarz—1969.

[8] Abstracted from material provided by Hyman Mandel, F.A.C.N.H.A., Administrator, Sunny Acres Convalescent Hospital, Fairfield, California.

tients. However, even the most progressive homes are reluctant to accept the mentally impaired elderly patient. Often referred to as "difficult," "hard to handle," "too senile," or "too confused to do anything with," by nursing home administrators and personnel, such patients are frequently refused admission. Those nursing homes that do not have adequate staff (and few, if any, activities to enhance the lives of their patients) will accept mentally impaired patients because such facilities rarely recognize the nature and degree of mental impairment and thus cannot care for such patients effectively.

The Sunny Acres Convalescent Hospital in Fairfield, California—45 miles from San Francisco—not only accepts the mentally impaired patient, but provides him with a wide range of medical and rehabilitative services. Indeed, many of the patients accepted here have been turned away from nursing homes in their own communities. Sunny Acres is licensed by the State Department of Health as an extended care facility. A majority of the patients here are referred from the San Francisco Geriatric Screening Unit. Others come from the State hospital, bay area welfare departments, general hospitals, social agencies, private physicians, and local residents. Of the 90 patients at Sunny Acres, 13 are "private" (paid by their own funds), 75 Medi-Cal (Medicaid), possibly because of the long-term nature of most of their conditions, only two patients are under the Medicare program.

The staff is comprised of a Medical Director, physicians, registered nurses, practical nurses, nurses aides, and consultants in dentistry, pharmacy, social work, occupational, physical and music therapy also work closely with the facility.

Sunny Acres has an on-going in-service training program (in cooperation with the Fairfield Board of Education) for nurses aides. In addition, a group of academically unmotivated local high school girls receive vocational training here to prepare them for work as home health aides. Many have chosen to go on to receive further training as nurses aides, and are ultimately employed at the home.

Programs include calisthenics, occupational therapy, and remotivation or group discussion, and a wide range of recreational and educational programs for the patients.

Sunny Acres Volunteers for the Elderly (SAVE) are recruited from six church denominations, as well as from high school "candy stripers." The volunteers plan birthday parties and games, but this program focuses on a one-to-one "friendship" basis with individual patients. This complements the remotivation therapy by small groups of patients and a discussion leader.

Drexel Home for the Aged [9]—At this home for the aged in the midst of Chicago's inner-city, an estimated 80 percent of the patient population has some form of mental disorder, frequently in combination with chronic illness. Most residents are low-income elderly; 75 percent are on Old Age Assistance. The home is affiliated with three hospitals in Chicago, including Michael Reese Hospital. Of the 246 beds in the Home, 136 are on four nursing care floors, which are usually filled to capacity. The Nursing Department includes 64 full-time and 10 part-time staff 17 of whom are registered nurses. The Home is licensed by the State of Illinois to provide sheltered care facilities, nursing care facilities, and special geriatric services.

---

[9] Information provided by Mr. Al. Mendlovitz, Executive Director, Drexel Home, Inc., Chicago, Illinois.

Care provided to these very poor, sick older persons at Drexel Home is regarded as exceptional not only because of the rehabilitative, medical and recreational programs offered, but also because patients could not receive such a range of care in a state hospital or in most nursing homes. Indeed many nursing homes refuse admittance to the mentally impaired, low-income elderly. Drexel Home, which is denominational (Jewish) is in a neighborhood that has changed over the years and is now one of the worst poverty areas in the city. Administrators of the Home have recognized that urban facilities cannot shut themselves off from their immediate geographic setting or community but must also work to make the community a better place in which to live. According to the Executive Director of Drexel Home, "We have discovered that . . . our potential for better patient care, a more effective work force, and a healthier community are really indivisible." Therefore, the Home has established an on-going community activities program, and it reaches out to bring the community into the institution.

The following summary, provided by Mr. Alfred Mendlovitz, Executive Director, indicates the range and scope of the services offered to the patients and the community by Drexel Home:

I. Training Programs in Process at Drexel Home

A. MEDICINE

1. *Medical Residents.*—Each month a medical resident is placed here for his geriatric affiliation by Michael Reese Hospital. (12 Residents per annum.)

2. *Psychiatric Residents.*—Psychiatric residents are placed here quarterly. (See below for more details.)

B. NURSING

1. *Licensed Practical Nurses.*—The Chicago Board of Education offers a program, of which 6 weeks are spent at Drexel Home acquiring practical experience under professional supervision. These classes are continuous except for August, accounting for eight groups of 10–15 trainees per group. (About 120 students per annum.)

2. Registered Nurses.—In cooperation with Michael Reese Hospital, 5–10 candidates for R.N. spend 4 weeks of supervised training in nursing problems of the aged. There are 3–4 classes per year, depending on the hospital's program. (About 50 students per annum.)

3. *Master's Nursing Placement.*—The Loyola Graduate School of Nursing recently placed a Masters candidate here for a 6 weeks practicum, collecting data for a research study on sitting and standing difficulties among the aged.

4. *Associate Degree Nursing Students.*—Two local Jr. Colleges, South East Jr. College and Kennedy-King College, have become interested in sending students for their practicum with us. (About 40 students per annum.)

C. SOCIAL WORK

1. *University of Chicago.*—The School of Social Service Administration places 5–10 Social Work Masters Degree students per year

with us, in all specialties, casework, group work, and community organization. They spend 2 to 3 days per week for one year, under the supervision of our Social Service and Administrative personnel learning treatment and planning in the field of gerontology.

2. *University of Chicago.*—Doctoral students—We also have several Doctoral candidates at the University basing their dissertations on data gathered at Drexel Home. See "Research Projects."

3. *Loyola and George Williams Masters Students.*—In past years our home has served as a field placement for students in Social Work from Loyola University and George William College.

4. *Career in Social Work Program.*—Each summer Drexel Home serves as a work center for two to four undergraduate students who are part of the Chicago Welfare Councils Career in Social Work Program.

D. OTHER

1. *Other Professions.*—In past years we have served as a field placement for other professions in our dietary, occupational therapy, and physical therapy departments.

2. *Occupational Training.*—The Cook County Department of Public Aid's Welfare Rehabilitation Service brings in 4–5 people, 4–5 times times per year, who spend two weeks learning basic job skills in our Nursing and Dietary Departments. (About 15 students per annum.)

3. *Home Health Aides.*—The local YWCA has a program to train homemakers who will provide help to ill or elderly persons in their own homes. Since September we have had several classes of 10–12 trainees, who spend one week with us learning the basic skills of homemaking with special reference to the personal needs of the elderly. (About 60 students per annum.)

All of these programs are funded from other sources, with Drexel Home providing a field placement setting for a course of training or research. We eagerly welcome students of all sorts, for in our experience they provide a fresh breeze of activity and stimulation which is especially necessary in a long-term facility. The students' critical attention is a spur to good staff practice, and their questions often inspire creative re-thinking of habitual activities.

These are benefits to our staff and residents over and above the help with resident care which the students provide.

To round out these traditional programs of training we are thinking of developing a new job category, which we would call "Geriatric Aide." Such a classification would include most of the skills now distributed among the roles of housekeeping, dietary, and nursing aide. Such a person would help us overcome the fragmentation now current in patient care, and at the same time ease the problems of administrative coordination of effort at direct service levels. The salary for such a job should be higher than current salaries for aides. This is a special project and is seen as developing a new service role for the industry, rather than just for our internal purposes.

II. The Meals on Wheels Program

To our deep regret, this program was discontinued January 1, 1970 due to lack of funds. Attempts to secure funding through the Model Cities program, the Illinois Department of Public Aid and Billing. Hospital of the University of Chicago have so far been unfruitfuls

The program ran for three years, serving two meals per day, one hot, one cold, delivered together, 5 days per week, to an average of 28 people at a cost of approximately $1,000 per year per person. Those served included the enfeebled elderly, some younger people with disabling diseases (Muscular Dystrophy), and those just returned from hospital stays and not yet able to serve themselves. They were referred by Public Welfare workers, hospital social workers and other professionals involved with their cases, and meal plans were made as part of an overall plan for each person. The clients paid from $2.00 to $4.50 per day for the service, with about 60% paying the lower figure. Public Aid authorized $37.15 per month for recipients. These collections represented about one half of the total expense, or $500 per year per person. The duration of service varied from several weeks to the entire length of the project.

The need for such programs of out-reach to provide direct services in the community was underscored by our discovery of numerous problems of the recipients for which we could find no adequate community based solution. Home health aides and transportation services, for instance, which are acutely needed, could be provided with a modest investment, producing a very high yield in physical and emotional well being. If we had had sufficient funds, I am certain that we could have developed the program into a valued resource for local physicians and others concerned with physical and mental health, at a fraction of the cost of hospital or nursing home care. We experienced some difficulty convincing local physicians, and some of the elderly themselves, to try the program. After using the service for a short time, however, most people felt it was very valuable. In some cases it seemed to meet deficits people did not know they suffered from.

III. Neighborhood Youth Project

For the past four summers we have hosted an OEO sponsored two month summer program, which pays 10th, 11th, and 12th graders from local schools $1.25 per hour for 25 to 30 hours per week job training at Drexel Home. They came through the Woodlawn Urban Progress Center, Roy Davis, Director, and have been primarily female. In the beginning we had 20 youngsters, but this was gradually reduced to 6, since we felt the best results were obtained if each trainee received a substantial amount of staff time rather than simply treating them *en masse*.

Our program has included an orientation day followed by assignment to department heads, primarily in nursing, clerical office, and occupational therapy. Some trainees have also been assigned to social service, dietary, housekeeping and physical therapy. One girl was hired in the fall of 1968 on our staff after termination of the summer program. Others have come to us for part-time jobs after school, but we have been unable to find positions for them. Several others have come for extended periods as volunteers after the program was completed. We feel that the results of the program are quite favorable. and we will be continuing it in the future.

IV. Community Activities of Drexel Home

A. BLOCK CLUB MEETING

Drexel Home has an Annex for ambulatory residents located across the street from the Home and the Block Club which includes that

Annex also includes the Home. I frequently attend the Club meetings, which are held monthly in Drexel Home's Conference Room. The group plans fund raising and Block events. Projects have included uniform Christmas lights for buildings on the block, Block parties, etc. These activities have, at various times, involved the local Urban Progress Center, the Woodlawn Organization, the local Democratic Organization, the Associated Clubs of Woodlawn, Inc., (all of which our Club is a member), and various private individuals.

B. PTA

Our facilities are used by the PTA of a local public school which does not have a meeting room large enough to accommodate the 50–100 parents who attend. They meet here about three times per year.

C. CRUSADE OF MERCY TOURS

Representatives of various companies are shown around the Home several times each year as part of the activities initiating local fund drives for the Crusade in Chicago.

D. MISCELLANEOUS EVENTS

From time to time particular problems emerge, or temporary programs are initiated, in which the Home can play a role as host, or provide voluntary manpower. Several, which have happened in recent years, are listed below:

1. Just before Mother's Day last year a group of students at the University of Chicago School of Social Service Administration brought in a number of children of welfare mothers. They used our occupational workshop and our residents as instructors to make Mother's Day gifts and other items.
2. The Union Of Hebrew Congregations has a summer program for teenagers called the Mitzva corps. They come from all parts of the nation. They were housed at the University of Chicago, and several were placed with the Drexel Home to learn about aging people and provide service to our residents.
3. The Lab School (the secondary school) of the University of Chicago has involved our residents in projects related to their students, for periods up to 6 weeks.
4. About a year ago a group of Vista young men and women spent several weeks here as part of their training for work with the elderly in rural communities.

V. PSYCHIATRIC SERVICES

Dr. Jerold Grunes, M.D., is our psychiatric consultant, visiting the Home ½ day each week. He normally sees 4 residents, by referral, for direct treatment, and then spends an hour with senior staff discussing the problems of particular residents and the practices of staff. He is also available on call. He is usually accompanied by two to four physicians in training, who come to Drexel Home once each week for three months as part of their psychiatric training. They are from Michael Reese or Billings Hospitals. All of these physicians provide intake evaluations, diagnostic work ups, and treatment.

They follow similar schedules, seeing about 4 residents each, and discussing the cases with staff. We have tried open discussions with direct service staff at group meetings, but this is not currently routine practice because of time limitations. We are seeking to expand these psychiatric services because of their great value in improving staff insight and directly treating residents' problems.

In extreme cases of psychiatric problems, probably only 1–3 per year, residents are hospitalized at Michael Reese, Chicago State or Manteno Mental Hospitals. Some return to the Home after treatment.

We recently tried an experimental plan with Michael Reese Hospital Psychiatric and Psychosomatic Institute, in which several residents became in-patient members of a geriatric therapy group. We are uncertain of the value of this to our Residents, but we hope to investigate this more thoroughly.

Ebenezer Home/Luther Hall.[10]—This home for the aged (172 beds) and nursing home (228 beds, of which 103 are for intensive care patients) is located in the model cities area of Minneapolis, Minnesota. Owned and operated by the American Lutheran Church in Hennepin County, Minneapolis, (non-profit) the facilities admit elderly persons regardless of race, creed or financial status. More than 60 percent of the patients in both facilities are on Public Assistance. As at Drexel Home in Chicago, some 80 percent of the patient population suffers from varying degrees of mental disorder.

The unique aspect of these two facilities is that although Ebenezer Home (home for the aged) and Luther Hall (nursing home) are separate and distinct units—located one block from each other—the staffing, programming, and training programs interact and provide a concept of comprehensive care for residents in the Home, as well as for the patients in the nursing home. Each facility has its own dietician and occupational therapist; and the nursing home has more professional (registered) nursing personnel than the home for the aged. Most homes for the aged have lengthy waiting lists of persons who need to be admitted to a protective care facility, and if a resident of a home for the aged is transferred to a nursing facility due to illness, his room (which has become his only home) at the home for the aged is frequently filled immediately. But at Ebenezer Home an ill patient is transferred to Luther Hall, secure in the knowledge that when (and if) he should recover sufficiently, his room will be waiting for him at the Home. Many elderly couples live at Ebenezer Home in comfortable quarters similar to a large one-room apartment. All residents of the Home are encouraged to bring some of their own furnishings and any personal objects (such as paintings, momentos, framed photographs) that they wish.

The administrators of these facilities recognized the need to provide additional supportive care and services to their mentally impaired patients and residents, and have employed remotivation therapy techniques for such persons (along with other occupational, social and recreational therapy) for some time. In December 1970, through a grant received from the American Lutheran Church, a special project was established at Ebenezer Home entitled, "Maintaining the Growing Edge: A project in Mental health—mental impairment," which focuses special attention on the mentally impaired patient.

---

[10] Information abstracted from material provided by Reverend Almon Brakke, Director of Special Services, Ebenezer Home, Minneapolis, Minnesota.

A special staff team was designated to screen selected mentally impaired residents for inclusion into a "Reaction-Response" group, which meets weekly. Although the project is a form of group therapy, each patient is treated as an individual. Special programming is developed to meet his growing capabilities as he improves. Each meeting is an "event" such as a sing-a-long, or a party, which includes reading aloud, word and number games, and handicrafts. The project is now well into Phase II, which includes the development of special programming for all mentally impaired residents in the home, providing opportunities for involvement through one-to-one relationships, group activities and individual treatment. In Phase III,[11] the Home will reach out into the community, utilizing treatment methods tested during phases I and II for elderly persons living in the surrounding area who are in need of such services.

In July 1970, Ebenezer Home was awarded a 3-year title III Older Americans Act grant from the Minnesota Governor's Citizen's Council on Aging for a community service project entitled, "The Model City Protective Service Project: The Surrogate Function." The Protective Service Program will provide surrogate services to elderly persons in the model cities area, through a multi-disciplinary approach which will provide access to comprehensive service, including social work, public health nursing, homemaker services, medical consultation and treatment, psychiatric consultation, and legal aid. In addition, the program will actively attempt to seek out isolated individuals in need of such services. A wide range of social, health and welfare agencies in the community are cooperating with Ebenezer Home.

COMMUNITY PROGRAMS

The Circuit Riders—Big Spring Hospital.[12]—Big Springs State Hospital, in Big Spring, Texas, serves a 48 county area, covering over 2,000 square miles. Because of the vastness of the area, many elderly persons residing in the community—but needing treatment and care—could not avail themselves of the services at the hospital. In 1967 through a title III Older Americans Act grant awarded to the hospital's Volunteer Advisory Council, the Circuit Rider volunteer program was established. Now in its fourth year of operation, the Circuit Rider program has more than 120 volunteers, with an average age of 70 years. Volunteers are trained by hospital staff and the volunteer advisory council to work with elderly patients in the hospital—and even more important—to work with returned patients and their families in the community, as well as with persons utilizing the hospital's outpatient facilities. At first, Circuit Rider traveled a sparesly populated rural area in six counties: Borden, Dawson, Scurry, Martin, Mitchell, and Howard. They informed elderly citizens of the services available to them at Big Spring Hospital, and transported them (in two ten-passenger station wagons) to and from the hospital, and mental health clinics in their communities. Transportation for shopping and other errands was also provided. Three satellite volunteer offices were established in Scurry,

[11] In 1971 the Home will complete application to the National Institute of Mental Health for Phase III.

[12] Information gathered from correspondence with Mrs. Betty Duncan, Program Specialist, Big Spring State Hospital, October 1969; Circuit Rider brochure; and spoken communication with Mrs. Carter Clopton, program Coordinator, Texas Commission on Aging, January 18, 1971.

69-261 O - 71 - 9

Dawson, and Mitchell counties as referral centers. Most offices employ elderly clerks, who coordinate the volunteer services, provide speakers from the hospital and related agencies to conduct training and educational programs in the community. In one area they organized a local auxiliary that works with discharged patients. As a result of the knowledge provided by the Circuit Riders, the hospital was able to establish Mental Health Clinics in these three counties. With the success of the volunteer program and the three mental health clinics, other communities sought similar services, and in 1969 the hospital established three additional mental health clinics and Circuit Rider referral offices in Gaines, Reeves, and Taylor counties. Three consultant psychiatrists travel with the Circuit Riders, bringing psychiatric services and treatment to communities where 8.6 percent of the population is over 65. Recently, a new mental health clinic was established in Ward county. Satellite Circuit Rider offices are planned for five other west Texas counties.

Volunteers are encouraged to invite interested visitors, family and friends of patients, to ride the "Circuit Wagon," thus broadening community awareness of treatment services at the hospital and the mental health clinics. Frequently this has led to the recruitment of new volunteers. In addition to providing transportation (vital to these sparsely populated rural communities), and services to elderly outpatients and those in the hospital, volunteers also work in their own communities as cooks, nurses aides, seamstresses, companions, telephone helpers, and letter writers for patients who have been released to the community. Bi-annual formal workshops are conducted for the Circuit Riders at Big Spring State Hospital, to discuss problems that may have come up with patients, new ideas for service programs, and to provide continued training for the volunteers.

The goal of the Circuit Rider program is to make available to all older citizens in the hospital's service area the resources for preventive measures to mental deterioration and to establish continuous programming of services linking these communities with the Big Spring State Hospital. The Circuit Rider program is well on the way to accomplishing its goal, and more. The volunteers, most of them elderly—and some, discharged mental patients themselves—have benefited from the program. Hospital staff reports that evidence of mental deterioration has been arrested in many of the volunteers, as they gave of themselves by helping others and became productive members of their communities, thus gaining a feeling of worth and usefulness. Indeed, as stated by the project director, "The Circuit Rider volunteer program is 'outreach' at its most practical grass roots level." [13]

Women's Worry Clinic.[14]—The first Women's Worry Clinic was held in Oklahoma City, Oklahoma, in 1959. Developed by the National Association for Mental Health, the concept of "Worry Clinics" for women has spread to many other cities and communities across the country.

---

[13] In written communication from Mrs. Betty Duncan, Program Specialist, October 14, 1969.

[14] Information abstracted from written communication with Mrs. Janet W. Livingston, Mental Health Educator, Northern Wyoming Mental Health Center; and material provided by National Association for Mental Health, New York City, N.Y.

The clinics were designed for the purpose of helping women cope with problems of day-to-day living, by joining discussion groups with other women who reside in the same community. Sponsored by State Associations for Mental Health, in cooperation with church groups (many Worry Clinics are conducted in local churches), local boards of education, social agencies or mental health clinics; the suggested format for a typical Women's Worry Clinic includes a morning devoted to separate "classes" for women of different age groups. There is, for example, a class for brides, one for mothers of elementary schoolchildren, another for mothers of teenagers, for the middle-age woman, and a "graduate" class for older women (the subtitle for the graduate class at a recent Women's Worry Clinic in Wyoming was "Baby Sittin'? Alone and Knittin'? Out and Gittin'?". During the afternoon session, all "worriers" meet as one group with group leaders (group leaders are professionals in the field of mental health) acting as panelists and stimulators from the audience.

Although this program is not specifically designed for the elderly, the inclusion of older women in a separate category, and then in the overall discussion group, has benefited many elderly women. In talking about problems of isolation, loneliness, fear and grief of widowhood, with other persons like themselves, these older women can more effectively deal with such problems. They also may come to learn that their problems are not "hopeless." Many friendships have grown out of the Worry Clinics. And finally, in the words of the Mental Health Educator at the Northern Wyoming Mental Health Center, where a successful "Worry-In" was conducted in the spring of 1970: [15] "Our mental health center staff feels that the most valuable accomplishment of the program was that it demonstrated to the participants that the Center is here to try to help people with problems, not just to treat 'crazy' people—made our services more acceptable and accessible to those who might be in need of our help." This is especially important for the elderly, who usually make very little use of Community Mental Health Centers or other Psychiatric outpatient clinics possibly because of the stigma so often attached to mental illness.

[15] In correspondence from Mrs. Janet W. Livingston, Mental Health Educator, Northern Wyoming Mental Health Center, Sheridan, Wyoming, September 22, 1970.

PART THREE

STATEMENTS ON MENTAL HEALTH ISSUES RELATED TO AGING AND AGED AMERICANS

The Senate Special Committee on Aging has received much helpful assistance and advice in the preparation of this report from concerned and informed experts. Statements by three such persons follow:

1. Dr. Robert Butler, consultant for this study, has provided two statements which express his concern about "age-ism" and other issues affecting the quality and availablility of care for the emotionally-impaired elderly.
2. Dr. Alvin Goldfarb, in his "Case for the Multi-System Provision of Comprehensive Mental Health Aid for the Aged," describes the need for making full use of State mental hospitals and other available resources while working toward a more coherent and genuinely helpful care system.
3. Dr. Stanley F. Yolles, former director of the National Institute of Mental Health, describes present and potential opportunities to prevent mental health problems of older Americans.

I. ARTICLES BY ROBERT M. BUTLER, M.D.[1]

A. The Mental Health Care of Older Americans Present and Future Prospects

For all too many Americans, old age is or will be the tragic culmination of a life of contribution to our society. Among the frequent poignant events of the closing chapter of life is the development of emotional crises and mental illnesses. One-fourth of all annual admissions to public hospitals, for instance, are of persons over 65 years of age. Nonetheless, only three percent of the budget of the National Institute of Mental Health is devoted to the study of the mental problems of old age. Many psychiatrists and other mental health personnel and psychiatric institutions have little interest in and/or feel unable to help the mentally-troubled and impaired old person.

Moreover, many states, burdened by the rising costs of mental hospital care and discouraged by the results of care of older patients, have transferred the latter to nursing homes, intermediate care and so-called foster care facilities. However, such institutions are not psychiatric, do not have personnel trained to care for psychiatric patients, and do not conduct research. Such institutions usually have lower standards of evaluation and care than mental hospitals. There may be minimal to no medical and social work coverage and no activities program. Transfer, moreover, is often associated with increased mortality.

---

[1] Research Psychiatrist and Gerontologist, The Washington School of Psychiatry; Faculty, Washington Psychoanalytic Institute and George Washington University Medical School; Consultant, St. Elizabeths Hospital and the National Institute of Mental Health; Chairman, D.C. Advisory Committee on Aging; Member, Board, National Council on Aging, Inc.; Member, Public Policy Committee, Gerontological Society; and chairman, Committee on Aging, Group for the Advancement of Psychiatry.

Our communities need high quality comprehensive medical and psychiatric reception, evaluation, and treatment centers. Among their purposes would be screening and referral in accordance with carefully attained results. Such a screening program as that in San Francisco is a most modest and incomplete beginning. Under much more ideal circumstances, some older patients would be referred to custodial care in nursing homes and mental hospitals, but many would also be referred for active therapy oriented toward discharge back to their homes. However, the success, indeed the validity, of such high quality primary centers depends ultimately upon the creation of high quality alternative services and facilities to match the varied needs of elderly psychiatric patients.

Thus, one conceives a range of *facilities* from medically and socially prosthetic nursing and/or social care environments to the active psychiatric treatment units of general hospitals to the active treatment programs of mental hospitals. And one conceives a range of *services*, from Hot Meals on Wheels to homecare to community centers to paid and voluntary community roles for older citizens.

Let us briefly review some of the factors that explain the under-utilization of psychiatric facilities by the elderly. Then, let us offer some suggestions toward expanding the mental health care of older Americans.

One crucial reason for the under-utilization of community mental health facilities by the elderly is the lack of interest and therapeutic pessimism of both the "gatekeepers" and referral sources (general practitioners, clergymen) and mental health personnel. In turn, such pessimism derives from inadequate education and experience in working with the emotionally-troubled elderly. There are a limited number of psychiatrists, psychologists, social workers, and others, who have developed skills and experience in the evaluation, care, and treatment of the elderly psychiatric patient. When operating under appropriate conditions, such workers report impressive beneficial results.

Robert W. Gibson [2] reported upon a survey of 49 private psychiatric hospitals concerning the treatability of older patients. Some 6,400 patients over 65 had been admitted from 1960 through 1964. Approximately 75 percent of these patients improved sufficiently to return to their homes within two months.

Illustrative of common reversible psychiatric conditions in old age—which often go unrecognized and untreated—are the acute confusional reactions and depressive states.

General practitioners refer older patients late in the course of psychiatric illness, if they refer at all.

With fundamental changes in the psychiatric curriculum and practical experience, the average psychiatrist, for instance, would discover that many mental health problems of old people are "amenable to traditional types of mental health intervention."

The notion that old people are concerned about the stigma attached to psychiatric treatment has been exaggerated. When the feeling exists, it is often an expression of the old person's family.

Poverty alone does not explain the under-utilization of the community mental health centers by the elderly. Indeed, other groups are even more disadvantaged.

---

[2] Gibson, R. W., "Medicare and the Psychiatric Patient", *Psychiatric Opinion* 7:7-22, 1970.

The poor black old who require psychiatric help are most disadvantaged.

Poverty is massive among the elderly—seven million of our twenty million elderly are near or below the poverty line. Yet Medicare and Medicaid offer more opportunities for the elderly poor than the young poor to gain psychiatric help. Many organizations, including the Health Insurance Benefits Advisory Council (HIBAC) have pressed for changes in regulations so that the community mental health centers can accept Part B Medicare payments.

In any case, people of all ages, including the elderly, are entitled —theoretically at least—to the services offered by the centers. But the vast majority of centers have not developed skills to help the elderly.

Psychiatrists and others interested in the elderly are working toward liberalization of present restrictions on both outpatient care and hospitalization for mental illness under Medicare. For example, there are efforts to markedly increase the annual limit on outpatient care of $250.

One of the most striking items of factual data explaining the underutilization of psychiatric facilities by the elderly is the absence of necessary outreach programs. Many old people simply cannot get to the treatment, not out of a "lack of motivation" but as a result of realistic obstacles. Physical limitations, unavailable transportation or inability to pay for it, mental confusion, among other factors, make it mandatory that the treatment go to the patient and/or that the transportation be arranged.

What can be done?

The National Institute of Mental Health must expand its efforts on behalf of the elderly to meet the continually increasing need. The Institute should be provided sufficient budget and personnel to take an active catalytic role in effecting changes in education and in community mental health centers as well as in research, both basic and applied.

A special Training Committee on Aging should be funded (similar to the one now operated so successfully in the National Institute of Child Health and Human Development) to increase the number of training programs in various mental health disciplines.

Guidelines should be developed and disseminated for use in treatment programs from home care to community mental health centers to state hospitals. Through the Group for the Advancement of Psychiatry and the National Institute of Mental Health, the author catalyzed a project under the direction of Dr. Robert D. Patterson to create a teaching guide: "Manual for Comprehensive Mental Health Care of the Aged." This booklet is now available.

Crash programs should be undertaken establishing traveling teaching teams of experienced professionals offering workshops for various mental health professionals. Especially recruited professionals located at various institutions would then continue teaching programs upon departure of the teaching teams.

Audio-visual aids, for instance motion picture documentaries of interview evaluation and therapy techniques, should be widely used. Along with the traveling teams, audio-visual aids could help make

up for the severely limited number of mental health professionals expert in work with the aged.

Criteria or conditions for participation in Medicare have been established—albeit loosely applied at times—for hospitals, nursing homes, home health agencies, etc.—but none have been established for physicians. It would be interesting to debate the following proposition: *Only* physicians including psychiatrists who have received education concerning the nature and medical/psychiatric problems of old age should be allowed to treat the aged.

Every community mental health center should offer services for all age groups, including the aged. Because of the special problems of the elderly, outreach services must be made available.

Pressure must be exercised to effect change in the "maintenance of effort" clause of the so-called Long Amendment to Medicaid whereby matching monies are available to the states toward state hospital care of the aged. At present there is little to no evidence that money received by states under this Amendment has resulted in improved care for the older patient.

Nursing homes also require psychiatric consultation and services. Socially and medically prosthetic milieus must be established to assure the best quality of care. Too often, custodial care means "no care."

Continuity and comprehensiveness of care cannot be supplied by slogans. Both prevention and home care have been neglected in our country and both human considerations and economic factors necessitate the development of preventive and home care programs set in the context of comprehensive, progressive care.

It seems evident that national comprehensive health insurance must come soon. Spiraling costs coupled with shocking inadequacies in the American health care system demonstrate that true preventive care for the old age must begin with prenatal care. We need now to devise total care systems that will be operative throughout the life cycle. Many groups, including a task force under the Department of Health, Education, and Welfare, are considering various national health insurance plans. Pre-paid group practices are likely to play a major role in the inevitable changing of American medicine.

One final matter of single importance:

The Joint Commission on Mental Illness and Health did not have among its participating agencies a group specifically concerned with the elderly (as examples, The National Council on Aging, The Gerontological Society, or The American Geriatrics Society) and did not include a psychiatrist recognized as a specialist in aging among its individual members.

I propose the establishment of a Commission on Mental Health of the Aging and Retired to this Senate Committee. This idea has found support in many quarters, including the President's Task Force on the Aging (Report, "Toward a Brighter Future for the Elderly," April 1970).

The mental well-being of older Americans will become increasingly important with added survival and leisure. The economic price will become enormous unless we succeed in finding solutions to the grave problem of arteriosclerosis and effective treatment programs for the emotional and mental problems of old age. Our current efforts suggest dim prospects.

B. Psychiatry and Age-ism: Proposals for Action in the Year of the White House Conference on Aging[1]

In this year of the White House Conference on Aging (November 28–December 2, 1971), organized psychiatry and individual psychiatrists should re-examine their professional responsibilities to old people, indeed to people of all ages, diagnostic categories, socio-economic classes and races. Psychiatrists must study their personal attitudes toward old age as well as the general cultural devaluation of the elderly, age-ism.

Old people are confronted by pervasive manifestations of prejudices. Regardless of desire, competence, and economic need, they are arbitrarily retired (unless they are jurists, politicians or the self-employed, including physicians and, let it be noted, psychiatrists. If old people try to work, they face age discrimination in employment (a bias that applies after 45).

Voluntary non-profit hospitals maintain quotas against the admission of Medicare and Medicaid patients. State mental hospitals try to reduce the admissions of old people (about 25 per cent of all annual admissions) on the ground that "senility" is not a mental condition. (If senility, in fact, exists, what is it if not a disease of the brain?) and that old people do better in the "community." Unfortunately the "community" usually does not have humane alternatives, given the lack of decent nursing, personal care, foster care and other homes as well as the absence of home care and outpatient services. The community mental health centers and outpatient clinics rarely offer care [2] to the elderly. Indeed, they have been known to reject people on the basis of age alone without even seeing the patient. In some places old people, including the chronically mentally-ill have been "dumped" by state mental hospitals on the overloaded community mental health centers.

Old people often are denied adequate comprehensive medical and psychiatric evaluation. They are easily categorized as "old" or "senile." Treatable disorders are overlooked. Old people, like young people, grieve, suffer anxiety and depression, develop paranoid ideas. Indeed they face crises in greater number, rapidity and profundity than any other age group. They lose loved ones, friends, jobs, prestige, social roles and status. They are frequently over-tranquilized, developing acute organic mental syndromes and Parkinsonism-like pictures. Because of poverty and near poverty they are frequently inadequately nourished and suffer undiagnosed anemia which also impairs mental functioning.

Psychopathology in general, acute and chronic brain syndromes and depression in particular rise with age. One study by the National Institute of Mental Health (reported by the World Health Organization) shows the following incidence in new cases of psychopathology of all types.

Age range:	*New cases per 100,000 population*
Under 15	2. 3
25 to 34	76. 3
35 to 54	93. 0
Over 65	236. 1

---

[1] A Guest Editorial for the Fall 1971 issue of Psychiatry, International Journal of the William Alanson White Foundation.

[2] In 1969, although the aged (65 plus) constitute nearly 10 percent of our nation's population, only 2.3 percent of all outpatient psychiatric services were delivered to them. (NIMH Biometry Branch Statistical Note 36, December, 1970).

Suicide, too, increases with age and attains its zenith in elderly white males. For nonwhite women and men and for white women the curve of suicide is bell-shaped, its greatest height being in the middle years.

Of the 20 million Americans over 65 years of age, some seven million barely exist at or below the level of poverty. Medicare covers only 45 per cent of medical care. It does not include dental care, hearing aids and eyeglasses, all clearly important to the mental and physical health of old people. Long-term care in inadequate nursing, personal care and other "homes" is generally deplorable.

While Thomas Szasz worries about the oppression due to legal commitment, there is another most serious kind of oppression—that which follows from the failure to provide services to many diverse groups in our nation who require help.

One would hope that the National Institute of Mental Health would have shown leadership on behalf of the mental health care of the elderly. Yet, the 1971 NIMH money for research in aging was $1.34 million which is only 1.1 per cent of the NIMH total ($117 million). The total amount for aging ($3.45 million) is 1.0 percent of the NIMH total in research, manpower development and state and community programs.

The National Institute of Mental Health has only a limited program in aging but no line in the budget, and no study committee of persons knowledgeable in the field of aging to consider research, demonstration and training grant requests in aging.

What To Do?

The NIMH should exercise leadership in stimulating research, training programs and services toward substantial improvement in mental health care of the elderly. Any breakthroughs in the prevention or treatment of organic dementia would relieve great personal suffering and save millions in institutional care.

The deans of medical schools and chairmen of the departments of psychiatry should be encouraged by the NIMH leadership to emphasize teaching and research related to geriatric patients. Psychiatric research and training centers should admit older patients and provide active rehabilitative treatment. Community mental health centers should not be allowed to deny services on the basis of age.

Specifically the following steps should be taken by NIMH.

1. The establishment of a Center [3] on the Mental Health of the Elderly within the NIMH.
2. The appointment of a review committee for research and training grant applications in the area of mental health problems of the elderly.
3. A first-year budget of $2.6 million for research projects in mental health and aging.
4. A first-year budget of $2 million for training. A crash program involving traveling-teaching teams should be established. The programs should be devoted to (a) the continuing education of trained mental health professionals in such areas as psychiatry, psychology, social work, nursing, occupational therapy and other

---

[3] Of NIMH's original Special Mental Health areas, there are now centers (or, in the case of Alcoholism, an Institute)—Crime and Delinquency, Minority Center, Suicide, Narcotic Addiction, Metropolitan Studies. Only *Children* and *Aging* do not have a Center.

disciplines in order to increase their skills and motivation to work with the elderly; (b) the training of nonprofessional personnel such as aides, orderlies, mental health workers, home health aides, homemakers, advocates for the elderly, and older people themselves for new roles in working with the elderly; and (c) graduate-level training of research workers in gerontology.

5. A first-year budget of $5 million for the support of a beginning network of service programs for the elderly. These programs should be established in places of high concentrations of old people—in inner cities and the rural areas. Some of these programs would include existing NIMH grant programs such as Community Mental Health, Hospital Improvement Projects, and Staff Development projects (and Health Maintenance Organizations as they come into being). Others would be created to serve immediate critical needs, such as mental health services for nursing homes, which now "house" many mentally- and emotionally-ill elderly without providing suitable care.[4]

Special attention must be given to service, training and research in the mental health problems of minority aged, who are extraordinarily disadvantaged.

There is growing support for the establishment of a Congressional Commission on Mental Illness of the Elderly. It is noteworthy that the original Joint Commission of Mental Illness failed to have either specialists or organizations concerned with the elderly represented.

America's manifold problems are well-illustrated by the tragedy of old age in America. As Senator Frank Church (D-Idaho) stated: "one and a half month's cost of the war in Indochina would fully fund the U.S. Administration on Aging through the end of this century" and "the Pentagon probably spends close to $40 million a year for publicity, yet only $32 million was appropriated for all programs under the Older Americans Act last year."

Psychiatrists could take leadership in examining the personal (countertransference) and cultural attitudes toward aging and the elderly that help account for the very limited support for and outright denial of care given to one out of every ten Americans. Aging is potentially the problem of each of us, yet our dread engenders denial.

II. THE CASE FOR MULTI-SYSTEM PROVISION OF COMPREHENSIVE HEALTH AID FOR THE AGED

(By Alvin I. Goldfarb, M.D.*)

We are faced by many public health problems resulting from the actual and relative increase in the number of aged and aging persons, and in the great increase in the actual and relative number of individuals who show symptoms of severe impairment or mental illness for the first time in old age. Their mental symptoms are usually accompanied by decreased functional capacity related to multiple physical illnesses and impairments.

---

[4] These five proposals were presented on May 28 at a meeting between Dr. Bertram Brown, NIMH Director, and representatives of the American Psychiatric Association, the American Psychological Association, the American Sociological Association, and the Gerontological Society.

*Dr. Goldfarb is now Associate Attending Psychiatrist in Charge of Geriatric Service at Mt. Sinai Hospital in New York City, Associate Clinical Professor of Psychiatry at Mt. Siani School of Medicine of the City University of New York, Associate Clinical Professor of the New York College of Medicine, and Consultant to the Jewish Home and Hospital of New York City, the Hebrew Home for the Aged of Riverdale, N.Y., and the Beth Abraham Home and Hospital of Bronx, N.Y. He was Consultant on Special Services for Aging in the New York State Department of Mental Hygiene from 1956 to 1968.

For a discussion of the role of the General Hospital in providing geropsychiatry, see article by Dr. Goldfarb in Appendix 4 of this report.

The magnitude of the problem we face is suggested by the fact that chronologically old persons who are brought to State psychiatric hospitals are very sick people. Their ills are usually physical as well as mental. The best way to help them is to improve the institution, not to offer partial solutions—including the usually illusory "return to the community"—based upon sorting by mistaken emphasis on medical, psychiatric, social or economic aspects of the individual case at a specific time.

Everyone likes to think of "saving" the old person from the State mental hospital, either in terms of rescue or in terms of preventing institutionalization of any kind. It is, however, too early in the evolution and development of methods and systems of providing medical, rehabilitative and protective care for us to rule out institutional use or to decide upon one type which must serve all purposes. At present the heterogeneous population of elderly persons has a wide variety of needs for medical and psychiatric treatment of short, intermediate and long duration. Many old persons need care episodically many times for the same or different conditions. Large numbers are continuously or recurrently ill. A substantial number have need of long-term protective services or supportive "prosthetic" milieus. All need varying amounts of psychiatric as well as medical care. Finally, psychiatric "know-how" on the part of care-taking persons is of great importance.

To serve mentally or physically ill old people, we need many types of facilities which should offer a wide range of services. Because personal, geographic, and community differences are great, such care should be rendered under a variety of auspices: voluntary-nonprofit, private-proprietory, and public. While ability to pay may serve to gain some persons special benefits, publicly assured financing should guarantee adequate care for all in old age. There should be no obstructions or impediments to giving such care. In my opinion, psychiatric hospitals such as are now a part of "State mental hospital" systems are still needed by a large group of patients if they are to receive good care. There are many old persons for whom no other facility or system can serve as a satisfactory substitute. For perhaps a majority of old persons with physical or mental disorders there is no bureaucracy which can adequately replace a truly well organized, financed, equipped and staffed State mental hospital" or Department of Mental Hygiene system.

Systems of State hospital type or such organizations will continue to be needed. Other systems should also exist which may place differing emphasis on differing levels of assistance to people who have differing needs without limiting the range of services to those specific areas above. For example: while it is expected that State hospitals have large psychiatric staffs for the care and treatment of both inpatients and outpatients the types of institutions now called nursing homes and residential homes also need psychiatric staffs and psychiatrically oriented personnel. For some, part-time psychiatrists or facilities for psychiatric consultation may suffice; others may require large well organized psychiatric departments. Also, non-hospital facilities should have affiliations in psychiatric units for inpatient care. All facilities which offer residential or protective care to old persons require internists, surgeons and other medical specialists such as dentists and podiatrists in varying numbers.

Before briefly discussing how adequately the projects described earlier in this document answer these problems, it will be helpful to review the characteristics of chronologically old and aged persons in State hospitals, old age homes, and nursing homes.* I will also discuss cyclical attitudinal changes (they could be called fads) related to the institutionalized elderly, with special mention of the present attitudes engendered in no small degree by the availability of new sources of funds under the Medicare and Medicaid programs.

These massive financial "directives" as to how care should be provided threaten to prematurely set our ways of caring for old people in an expensive yet inadequate pattern.

THE INSTITUTIONALIZED ELDERLY**

About one million of the approximately twenty million old persons in the United States are now in institutions. Many more need protective care in hospitals, "homes," and well regulated congregate living arrangements. This actual and potential institutional population is heterogeneous. It includes persons from 65 to well over 90 years of age, of varied ethnic, religious, cultural, occupational and socio-economic backgrounds, who differ in family, friends, personal resources, energy, interests and illnesses, as well as in physical and emotional state. Their psychiatric conditions also span a wide range. In some, disorders are brought into old age from youth, in others depressive and paranoid reactions develop or first emerge as significant in old age; organic mental syndromes, very often complicated by disorder of affect or thought, are present in the predominant number.

There has been much discussion, both lay and professional, about how the needs of this varied population of aged persons can best be met. Personal prejudices, the bias of vested interests, misconceptions about society, underestimation of the number of afflicted individuals and of their needs for comprehensive health care, and—not least—widespread reluctance to finance expensive services, have influenced or blocked the development of institutions and their patterns of care.

Prior to 1950, the burden of care of old persons with combined psychiatric and physical illness was carried in large part by State hospitals and was shared to some extent by Homes for the Aged and chronic disease hospitals. Overcrowding in State hospitals and the great medical demands made by a large number of acutely ill first admissions in old age whose death rate soon after entrance to the hospital was extremely high, led to protests, surveys and claims that State hospitals were being used as dumping grounds for the incurably ill aged and poor, that medically ill were being misdirected, and that large numbers of relatively well aged were kept in State hospitals simply because "they had no place to go." In the 1940's there was

*"Old age homes" are voluntary, non-profit, nonsectarian facilities usually endowed, supported, and maintained under sectarian auspices—e.g., the Mary Manning Walsh Home, Peabody Home, The Jewish Home and Hospital, the Hebrew Home for the Aged. They are selective in their acceptance of applicants, have long waiting periods which tend to influence the characteristics of admitted residents, and range in type from small and ill equipped to large quasi-hospital facilities. "Nursing homes," up to the present period, have been private proprietary, poorly staffed institutions which, although relatively nonselective in their admission policies, tend to dismiss problem patients later on. Since the creation of Medicare "extended care facility" and "intermediate care facility" standards have pressed proprietary nursing homes toward quasi-hospital functions which chiefly depend upon the patients' physicians for care and direction. Even more recently many proprietary homes have been moving away from accepting Medicare-financed patients of any kind and toward admitting persons whose private income, or Medicare status guarantees payment.

**This section—and the following section on Attitudes and Mortality have been adapted from a chapter by Dr. Goldfarb on "Institutional Care of the Aged," in BEHAVIOR AND ADAPTATION IN LATE LIFE, published by Little, Brown and Company (Inc.), 1969.

much talk about excluding aged "homeless" persons and among other efforts to decrease the state hospital burden was the passage, in one State of a law forbidding State hospital admission or retention of dotards; this was soon rescinded.

These claims that State hospitals were being overused and abused as a site of care for persons who became ill, homeless or poor in old age were actually exaggerated. For example, the examination of patients in Connecticut State Hospitals by Schindell, at the time the furor about "mistaken admissions" was at its height, revealed that very few could justifiably be transferred to other types of facilities, not to speak of private homes; furthermore an examination of the categories of hospitalized old persons reveals that first admissions in old age constitute only 12 percent of the total hospital population and despite the fact that they might have constituted 30 to 40 percent of all first admissions in a given year they are only one fourth to one-third of the hospital geriatric population. It is patients who have aged-in-the-hospital who constitute by far the largest number of old persons in state hospitals. They are chiefly schizophrenics. A relatively small proportion entered with affective disorder, drug dependence or organic mental syndromes of relatively early occurrence. Many have proved resistant to therapy or have become withdrawn examples of the "hospitalization syndrome" which emerges with relative neglect. Others are relatively well adjusted within the protective hospital setting.

Recently there has been renewed agitation to reduce the number of old persons in State hospitals and this has been attempted in several ways: (1) by transfer of chronologically old persons—predominantly the well adjusted, the chemically restrained, or the relatively meek and submissive members of the aged-in-the-hospital group—to nursing homes, boarding homes, lodgings or foster homes; (2) by exclusion "at the gate" of chronologically old persons who appear to be physically acutely ill, who appear likely to become permanent residents, who appear to be free of gross affective disorders.

In the 1950's the growth of proprietary nursing homes burgeoned; regional overbuilding and empty beds led, in part, to the recruitment of "improved or well" or "well adjusted" State hospital patients to fill them. This was accepted as a solution to hospital overcrowding and was welcomed as a means of decreasing direct financial responsibility by many State hospital systems. Also, it was heralded as a humane "return of aged patients to the community." The wholesale transfer of patients to nursing homes was advocated as the use of a preferred alternative to State Hospital Care. In fact the predominant number of transferred persons were from those who had aged-in-the-hospital and not from the group of persons first admitted in their old age. Moreover, the change of institutions was the equivalent of transfer from one inadequate, poorly staffed backward to another where space, medical and general care, helpful personnel and "community life" either within or outside were less rather than more available. More recently, especially as Medicare and Medicaid have increased available funds, the use of nursing homes as "alternatives" to the State hospital has been advocated—and assured for selected patients—by the use of pre-admission screening teams.

Even well before these efforts to use "alternatives to State hospital" old persons with psychiatric disorders were found in a variety of institutions. These are variously and confusingly named. Two general

types in addition to the State hospital can be more or less clearly identified: homes for the aged (OAH), and nursing homes (NH). Each of these types of facility is at present in an accelerated transitional state because of Medicare and Medicaid financing. Therefore the type and quality of functioning of institutions of the same general type tends to vary from place to place and time to time. There are wide variations in size, staffing, programs and quality of care, as well as in cost to the consumer.

In its early years, Medicare provided money to old persons for a three to four month period of post-hospital care in specified nursing homes. This caused changes in the selection of patients by many of the homes. In an attempt to raise and maintain standards of nursing home care, Medicare reimbursement was originally predicated upon a nursing home's rehabilitative, restorative efforts, and its staff and facilities thus giving rise to the so-called "extended care facility." While praiseworthy in its intent to elevate standards of care these rulings have had considerable but not entirely desirable, influence upon patient selection and care. They require a "re-thinking" of what and how services shall be paid for.

By making large numbers of persons eligible for relatively short-term care in nursing homes which improved their staffs and programs—or appeared to do so—Medicare created a large population of affluent consumers. They were preferable to persons who had to pay their own way on limited personal resources or welfare aid, because they were below Medicare age or had exhausted its benefits. Thus while persons may appear to be selected on the basis of potentiality for rehabilitation as suggested by Medicare, this selection was greatly modified by a view to the individual's financial resources. Admitted freely are the rich and sick, or the poor and well; while the rich "well" are acceptable but the poor and sick are unwelcome. This is a matter of common sense—a move from Medicare payment to full payment for continued care by a rich patient provides a stable population making for economic security of the institution; the poor "well" can be discharged within reasonable period before the expiration of Medicare reimbursements and make the place "look good;" relatively well rich similarly speak well for the restorative function of the home but contribute to troublesome turnover; as for the poor sick—they, unfortunately, present a problem of disposition unless the home is willing to continue them at a considerable reduction of rate. Proprietary nursing home discrimination against persons with long-term needs for protective care, unless they have personal resources, is further evidence that facilities develop in accordance with financing; "the patient goes the way the money flows." Poor persons who need care because of varying degrees of organic mental syndrome, with or without physical functional impairment, have "no place to go:" they are not welcome in state hospitals, have a limited appeal to extended care facilities, are now faced by a short supply of low-cost nursing home beds and a scarcity of, as well as the discriminatory, selective practices of old age homes.

A second problem arising from the creation of the "extended care facility" concept of classification has been its effect on voluntary non-profit homes for the aged ("old age homes")—especially the large, urban, well-staffed quasi-hospitals, which contain the highest proportion of the Nation's "old age home" beds. These homes, for purposes of reimbursement under Medicare provisions, are being

categorized as extended care facilities and accredited as such rather than as hospitals even though they provide complete medical care short of surgery. In actuality such homes now receive few or no patients on a Medicare reimburseable basis—because such admissions must be within a ten day period after discharge from a general hospital and old age home waiting periods must exceed this by far because of their low turnover—about 18%, or 80 possible admissions, to a 500 bed facility a year. Thus, unless methods of processing applicants is changed, they are relegated to the lower Medicaid or Welfare reimbursement on the same basis as non-extended care proprietary homes even though they provide far more facilities, staff and restorative programs than the so-called "Extended Care Facilities." For example, extended care facilities provide no medical care; this must be privately obtained and separately paid for by Medicare as a "home" or "office" visit. Old Age homes which now provide good care, including medical and psychiatric care, cannot be reimbused for it; but extended care facilities are being reimbursed to a greater extent for doing far less, for selected groups and for only limited periods. For these reasons there is now much confusion about future developments.

What this bodes is that there must be a decrease of staffing and facilities in old age homes and a decrease in the quality of service. If Medicare funds are not available to them and Medicaid payments are kept low even the best of the O.A.H. may be forced to lower their standards of care. Voluntary non-profit old age homes may then fall to the level of the type of the proprietary nursing homes which do not qualify as extended care facilities and together with them will provide for the long-term housing—one can scarely call it "care," of chronically impaired old persons. Simultaneously, the number of available beds for such care may decrease because of the lack of economic incentive on the part of nursing homes to provide such beds. At the same time abuses of Medicare will lead to curtailment of extended care facility reimbursement and its usefulness to the poor aged. Also there will have been escalation of costs of care which may not be reversible. It is to be hoped that as this problem of welfare and public health becomes more pressing, through legislative or other public action, there may be changes in the allocation of funds, in State hospital policies, and in the regulation or implementation of Medicare and Medicaid which will improve matters. Already, in many States there have been moves toward the strengthening and expansion of State hospital systems despite talk which indicates the converse.

INSTITUTIONAL POPULATIONS

Contrary to popular beliefs, old persons do not reach old age homes for social reasons, nursing homes for medical reasons, and State hospitals for psychiatric reasons.

There is inadequate understanding on the part of professionals and laymen alike that there are complex admission procedures and a variety of plans for financing plans in the variety of institutions. Mistaken ideas may lead to unreasonable demands upon families to "make arrangements" for a patient's care. These misconceptions are all too often shared by social workers who, despite their presumed training in welfare matters, often have scant knowledge about nursing home or old age home facilities, staff or procedures in general and little or no knowledge about local institutions.

The majority of persons who come to live in the institutions as first admissions in their chronological old age do so when in their late 70's or 80's. The presence of protective, caretaking persons such as a mate or children favors chances of the person's admission to an old age home as does the existence of good income of one's own or of the family's: many such persons, even if extremely incapacitated or disturbed, can wait out the time required. Years of schooling are a fair index of socio-economic status and are illustrative of the same point—the better off socio-economically, the less chance of nursing home or State hospital use. This is now changing as nursing homes which have moved toward extended care facility status are developing areas of long-term "old age home" type care in response to prompt admission of rich aged ill on a Medicare basis and extension of their care on a personal payment basis.

While the immediate factors leading to institutional care include advanced age and debility or multiple impairments—of sight, hearing, ambulation, mentation and in self-care—together with a need for care, these are usually joined by an absence of available resources such as money or family sufficient to provide a "one bed nursing home" (or hospital) in their own home. The proportion of men and women may vary greatly from one institution to another. They may be based upon facilities available but, in general, women tend to outnumber men by at least two to one; in some homes for the aged the ratio is as high as 7 to 1. This is because they live longer than men and outlive their usually older spouses, thus providing a large population at risk of institutionalization on account of age and the absence of a protective mate. Conversely men of considerable disability may be maintained at home by younger and functionally more capable wives. Persons of either sex, more often women, are frequently maintained outside of institutions by children who also provide "protection against" institutional use. Nursing homes and old age homes have been, almost invariably, permanent residences; for State hospital patients the existence of a spouse or children increases the chances of leaving the hospital at times for home, at others for an "alternative" institution. The better educated and socio-economically more advantaged tend to reach institutions later than their poorer counterparts, and this is more likely to be a home for the aged or, except for the very old whose severe state of long duration leads to use of a State hospital. Men who have never married appear to make use of institutional protection earlier than equally disabled married men or widowers. The youngest and oldest of old people are admitted to State hospitals: these ends of the age spectrum are represented, respectively, by functional disorders, and by severe brain syndrome in the presence of a relatively sound body. Admissions to old age homes and State hospitals are usually directly from home, whereas admissions to nursing homes are most frequently from general hospitals.

Disturbed behavior such as suicidal attempts, attacks on others, dangerous wandering or confused and dangerous misuse of household appliances are frequently symptoms which lead to psychiatric hospitalization; the loss of protective persons by death, or the loss of accommodations or changes in neighborhoods, as well as needs for protective care, often lead to application to old age homes on the part of persons who can foresee waiting the 3 months to 3 years required; crises, such accentuation of pre-existing impairment by

69-261 O - 71 - 10

acute illness, accidents or a sudden shift in social circumstances, frequently leads to nursing home care by way of the general hospital or, less frequently, directly from home.

As noted above, auspices, admission, and retention policies and procedures, and modes of financing result in mutual selection of patients and institutions which is not strictly based upon personal needs or institutional abilities to meet them. This results in institutionalized groups which overlap in their physical, mental, and social characteristics. This is contrary to the common impression that each of the three types serves a separate segment of the older population.

Old age homes do not serve only social and retirement needs—over 50% of their beds are "infirmary" type, caring for grossly impaired and disabled aged persons; nursing homes serve a large number of relatively ambulatory, energetic and physically well but moderately to severely mentally impaired aged; State hospital populations of persons first-admitted-in-old-age until recent action to hold chronologically old persons out of State hospitals by fiat include a few relatively young old persons (60–70) with functional disorders, and some with organic mental syndromes related to "cerebral-arteriosclerosis" or pre-senile brain disease, a very large number of middle-age old (70–80), most of whom have organic mental syndromes of the senium, often in association with disorders of affect or though content, and a substantial number of the very old with relatively uncomplicated severe organic mental syndrome.

Persons with organic mental syndrome (chronic brain syndrome-CBS) are found in each setting; the proportion of the severely afflicted, however, is less in old age homes than in nursing homes, and is highest in State hospitals. Also, persons with disorders or mood and content associated with brain syndrome are found in all, but there are fewest in old age homes and more in State hospitals than in nursing homes. Also, persons with poor physical functional status and multiple impairments or chronic illnesses are found in each type of institution—the highest proportion being found in nursing homes, fewest in State hospitals. It should be noted that until recently less than 10% of persons coming to State hospitals in their old age had a disorder of affect or thought in the absence of an organic mental syndrome. On the other hand, for private psychiatric hospitals (prior to Medicare) the majority of persons admitted in old age suffered from disorders of affect (depressive reactions), a few were paranoid, and organic mental syndromes made up the rest. Now that general hospital psychiatric wards have been developed the largest number of old persons with affective disorder will go (admission policies permitting) to such units although the State hospitals because of their commitment to developing as intensive care centers, would welcome them. A further reason for State hospital competition for their patients is their value as payers via Medicare. In sum, with advancing age an increasingly high proportion of old persons reach institutions. When found in the institutions over 30% are bedridden, about 25% are incontinent, and the majority are constantly disoriented for time, place, and person, have gross memory defects, obvious difficulties in doing the simplest of calculations, and have a dearth of general information. The physical functional status of these persons is usually poor, active disease is the rule and most are depressed in some degree; many are paranoid. For all—whatever the name of the institution or its categorical type—because of the vulnerability of old

persons with even minimal brain syndrome to confusional states, disorganized behavior, agitation, depression and angry outbursts—psychiatrically oriented care is a requirement. Whatever the instituion, the patient's needs are such that it can be said; "If medical care is good, psychiatric care should be improved; if both are good social services should be improved; if all are good, all should be improved."

Attitudes Toward Institutional Use

Old persons in general are opposed to the use of institutions; this is more the rule than the exception, and is most obvious in the clearly mentally ill, the subtly mentally disturbed, and in the oldest and the most impaired. Thus it is that those who need protective care the most want it the least and may oppose it more vigorously, whereas those who may need it the least are less resistive to accepting the change in residence and this makes it obvious that one reason aged persons who need protective institutions also need psychiatric assistance is the intensity of their feelings that institutional use constitutes rejection by family and friends, and a loss of independence.

Unfortunately, the low quality of institutional care, however attractive the physical plant, tends to reinforce such beliefs and attitudes. Institutions are for the most part so poorly equipped, staffed and organized, that the resistance of families of aged persons to making use of them is more frequently related to realistic appraisal of the site of care and anger against "the system" than to guilt based upon giving the care of the parent over to others or, as is so often asserted, upon "unconscious hostility."

Institutional care is usually regarded as a prelude to death by applicants and their families rather than as a new, useful, experience in community living such as it can be in the best old age homes and could be in many state hospitals which attempt to become communities in themselves as well as to remain related to the outside world. Unfortunately, most homes, especially proprietary nursing homes, do not have the potential for becoming self-contained communities and are by no means a part of the large community. Therefore, they do become points at which old persons with little or nothing to do, senses, minds and emotions blunted by drugs, simply wait for death.

Entrance into residence of such poor quality tends to downgrade the individuals image of himself; his disability may become greater and there may be development or exaggeration of psychological and emotional disorder. Institutional deterioriation can be counteracted by the provision of "community type" activities; sheltered workshops in hospitals or homes, recreational thereapy, hotel type accommodations, and the contagion of high morale in well motivated staff: these improve concept of self, improve behavior, and help decrease objections to entrance into homes as well as to continued residence in them.

Mortality

Mortality is higher in institutional populations than in the general population. Taken as a group and excluding those acutely ill persons who die in the first three months after admission to a psychiatric hospital, about 25% are dead within the first year, over 40% by the end of the second year, over 50% are dead by the end of the third year

and the percent dead after four, five, six and seven years is 65%, 73%, 79% and 82% respectively. The death rate is higher for males than females and is exceptionally high for persons who have severe chronic brain syndrome as determined by psychiatric or psychological test or by a high degree of physical functional impairment or incontinence.

The high mortality of State hospital patients in the first year and especially in the first few months after admission is undoubtedly due to their moribund or preterminal condition. Many aged persons in their last few months of life become extremely difficult problems of management: noisy, destructive, impulsive, assaultive or self-damaging to degrees which endanger others as well as themselves. When medicated they may become more disorganized or comatose. Their nursing needs are high and their needs tend to exceed the available facilities in general hospitals. Consequently, in desperation they are sent to the psychiatric hospital. The latter, unfortunately, has not always been well enough equipped or staffed to manage the multiple medical problems of these patients. Depsite the likelihood that the best of medical care would make little difference to most; might prolong the lives of a few for a short time, and of an exceptional patient, for longer, there has been criticism of State hospitals for their high death rate.

Perhaps it is partly in reaction to this that State hospital systems have tended to declare themselves out of bounds to the medically acutely ill aged patient whatever his mental status. Studies have demonstrated that mortality is high even for aged persons who are not acutely ill and who have reached non-hospital institutions. Presently available data obtained by evaluation of non-hospital institutions, following the course of transferred patients, and by longitudinal study of institutionalized persons points to the relation of mortality to the basic condition of the patient rather than to the facility, program or transfer. In general our data suggests that given adequate basic shelter, food and general medical care the life span of severely impaired and disabled aged persons in the three major types of institution is related to their physical condition or "viability." It seems doubtful that the provision of extra services greatly prolongs life in the very ill although they may add immeasurably to comfort. Conversely, the relatively well may live somewhat longer in shelters which have programs and services which contribute to pleasure and the maintenance of dignity. The relatively robust, also may react favorably to shift or change in domicile, whereas for the severely functionally impaired shifts appear to make demands or lead to relative ne lect which may shorten life.

ATTITUDES AND MYTHS

There are a number of commonly held beliefs about persons who have reached, or appear to need, institutional care in their old age. Some of these ideas can be summarized as follows: "Aged persons in our society are rejected and neglected and discriminated against; they are discarded by selfish, callous families and are relegated to loneliness and discomfort which affects their mental and emotional well-being; when they become ill, they are quickly dumped into State hospitals, nursing homes or old age homes where many of them die from the shock of transfer or from humiliation; large numbers of them are forced to remain in institutions simply because they have no place

to go and this largely because their place in the community has been permitted to close in behind them; the children of this generation lack estimable character and virtue—they make one wonder how it is that 'while one parent can take care of twelve children, twelve children cannot take care of one parent.' "

Such seemly compassionate remarks which appear to be exhortative toward improving the sorry lot of the aged are actually mis-statements which tend to confuse thought and to block social action. They tend to turn one away from social organization aimed at meliorating a major public health and welfare problem.

Thoughtful review of the general conditions noted above supports the contention that only persons with great need for institutional aid reach such points of care. There is no evidence that families "dump" troublesome old persons into an institution, State hospital or other. To the contrary, the presence of family tends to be a major "protection against" institutional care often to the disadvantage of the patient and contrary to his needs. It is more the rule that families wait too long for and fight against the use of institutions, than that they make unnecessary use of them. Individual capacity for self-maintenance or the existence of personal and familial resources helps impaired persons avoid institutionalization; an absence of family, the presence of excess disability favored by ignorance, psychological or emotional disorder, or alcoholism, increases an individual's chances of institutional use. The question "is institutionalization really necessary?", for those found in these facilities can best be answered by the research findings which have demonstrated that it is usually a last resort—and a late solution—on the part of persons helping the aged ones, rather than a properly timed search for assistance.

DISCUSSION OF PROJECT STUDIES

If this essay is by implication adversely critical of the projects or programs described earlier in this report, it is because they deal with limited aspects of the overall problems. They remain "good examples," however, in that they illustrate the size and diversity of the problem. Each of the projects has its strong points. Each has many weaknesses. No one of them can be heralded as a model solution for the problems of the aged.

The Harlem project, for example, is a helpful, relatively inexpensive innovation but it does not take care of large numbers of persons who need a protective setting which cannot be created for them in the community at large. At Swope Ridge, where a protective setting was provided, it was discovered that adequate comprehensive care could not be provided on Medicaid financing alone.

All old age homes are now very much aware of the impossibility of providing adequate service and care at low rates. Such seemingly astronomical rates as $36 a day, $42 a day, or $50 a day are being found to be insufficient to provide the physiatric, rehabilitative, and psychiatric care; the recreational activities; personnel such as the "lifters", the transporters, cooks and aides, that sick old people require if they are to be more than "stored away". It cannot be over-emphasized that meeting the needs of aged patients in nursing homes, old age homes and related facilities, costs money and lots of it.

Most of the State hospital and "community" programs being developed across the country to serve and care for the mentally impaired elderly—including those described in this report—actually serve one type of patient in a relatively homogeneous group for whom the care is adequate because it is applicable. The concepts of care presented at Ypsilanti, for example, are based upon the treatment of persons who became ill early in life or were hospitalized when relatively young and remained in the hospital for a variety of reasons. Similarly, the North Carolina project deals with individuals who, for the most part, have also aged in the hospital but are now accommodated to institutional life or are relatively manageable because of drugs. The transfer of such patients—or even those who are first admitted to State hospitals in old age—to so-called community facilities is usually a transfer to a nursing home equivalent to a hospital "back ward." Return to truly independent living as community citizens is difficult or impossible because of the irreversible impairment of these people. Return to living in their own homes or in foster homes is expensive and unsatisfactory because of the lack of adequate facilities and manpower to support and to serve this aging population in private residences. The provision of medical and psychiatric care outside residences for congregate living which is equivalent to that now given in a good State hospital would require a far greater increase in facilities and manpower than the provision of protective settings in most prosthetic milieus for life-time care. This does not imply that more and improved services for keeping old people at home are not needed; it means that these alone do not solve all the problems, or any of them at lower cost.

In California, the San Francisco Geriatric Screening Project deals primarily with first admissions to State hospitals; while this program is commendable in many respects, it may merely be aiding the State in a successful attempt to block the elderly from admission to State hospitals without providing more suitable care. Their follow-up reports attest to having achieved decreased admissions to State hospitals without demonstrating that this has been good for the patients or their families. Some recent reports of similar action elsewhere suggest that the transfer of selected, relatively healthy old State psychiatric hospital patients to nursing homes does not increase mortality but such transferees are "less well-adjusted" (not as happy?) as their peers who remained in the hospital setting. This implies that a not-so-good State hospital may be better for the person than a "good" nursing home.

All of these projects can be considered as possible helpful innovations. Each has its place within a complex of care-taking programs. We still need "institutions" which can care for large numbers of older persons who need protective settings in a flexible way.

This leads to a consideration of programs like that offered at the Philadelphia Geriatric Center. Persons interested in admission to this facility encounter many difficulties posed by voluntary non-profit homes for the aged. It is in high demand, has a long waiting list, a large "catchment area", a low turn-over (old age homes do not discharge patients and have an average death rate of about 15 to 20 per cent a year unless they admit acutely or severely chronically ill patients). People in crisis cannot be admitted. Even if the list were short, this kind of institution does not have hospital facilities which permit direct admission of the acutely ill. It is selective in its admission policies to exclude the emotionally ill and severely mentally impaired.

But the Center does provide a broad spectrum of services and programs and it does try to provide for and continue to treat persons who become ill or impaired in any way while in residence. This center is one of many demonstrations of what can and must be made available for the large number of old persons who need long-term protective care and prosthetic milieus. It provides comprehensive care. Under the direction of Arthur Waldman, those who have participated in developing and staffing the Philadelphia Geriatric Center have provided an excellent model for emulation by public or proprietary organizations. It could be more helpful if it could include facilities for the admission of more severely ill patients—as was done in the past by the Beth Abraham Home and Hospital, Bronx, New York—and of acutely ill patients. This would require its expansion to include hospital staffing and facilities. Unfortunately, when such moves have been made by long-term care facilities in the past, they have resulted in the abandonment of long-term care in favor of the treatment of acutely ill and the provision of diagnostic services.

There are other homes for the aged similar to the Philadelphia Geriatric Center, and equally good, in many cities. Deficiencies in service, however, are freely admitted and regretted by the best of them. Few old age homes with a wide spectrum of facilities can admit patients as quickly as they would like. Almost all have long waiting periods. Most are very expensive and cannot support themselves on Medicaid or welfare fees alone. Almost all are highly selective in admission procedures: persons with brain syndrome, emotional disorder or a history of psychiatric hospital admission, and who have physical illnesses which require a great deal of care, are excluded.

Even the Beth Abraham Hospital and Home in Bronx, N.Y., has been forced by the high cost of care to exclude brain damaged but ambulatory patients. Debilitated patients with brain syndrome were admitted by this home at one time but now even they must be excluded because their "decent care" costs far more than can be afforded.

Many homes still require that the individual donate his estate, if he has one. This is depressing and frightening to many older persons because they had, logically, hoped to bequeath their possessions to their families, and now find themselves dependent, with no control over their financial resources and with no hope of leaving savings to their children even if their life expectancy is short. Thus, the needs of good homes for sustaining income runs counter to the sustaining hopes and expectations of their applicants for admission, leading not only to expensive delays but also the depressions and family conflict. Many old people do not understand the home's financial arrangements and may enter into contracts which in effect are transgressions of their civil liberties because they separate the person from his resources. Homes often do not recognize the problems of persons they are admitting and are not actually equipped to cope with them with resultant suffering on the part of both. A large problem facing most facilities of this type is the lack of public, including governmental recognition that they are, in actuality, hospitals and that they are not places to which people retire for social reasons.

Indeed, there are persistent misconceptions about the elderly patient population in all types of institutions. Voluntary nonprofit old age homes are generally considered to be retirement centers which

should be converted to apartment house or cottage facility use; nursing homes are considered to be institutions for those who need nursing care; and State hospitals* are thought to be institutions for people with mental illness. Nothing could be further from the truth. Each of the facilities must provide the wide range of services needed by *each patient:* the physically ill need psychiatric and social aids, the mentally ill need medical and social aids, the socially ill need and require medical and psychiatric assistance.

While there are more relatively healthy, ambulatory persons in old age homes than in nursing homes, and more mentally ill and disturbed older individuals in State hospitals than in old age and nursing homes, the same health and mental health problems are found in all three types of institutions. State hospitals must be ready to provide residential and rehabilitative and recreational—as well as medical—services; nursing homes must do the same and provide some psychiatric care.

There are a variety of socio-economic, cultural factors which determine who reaches where, which makes overlap of needs for care unavoidable.

It is important to understand that many very sick old people can and will be well-cared for wherever they are because they have effective facilites. Their needs can be met in different kinds of facilities than old persons who come early to public care for socio-economic reasons. Such differences cannot be simply legislated out of existence. Personal, occupational, educational, and ethnic—to name but a few—differences lead to different paths of approach to care and acceptance of care. A multiplicity of types of providers of care is desirable: public—including the State hospital—and private, including voluntary nonprofit as well as some proprietary institutions.

CONCLUSION

We must try to make plans which take into account the varied backgrounds, attitudes, and needs of different segments of the aging population.

That is why I believe in the continued availability of a number of systems of care. All types of institutions—State hospitals, homes for the aged, nursing homes, general hospitals, veterans hospitals and agencies of many kinds—can and should play an important part in offering care to old persons. In each, a wide range of services is required for the wide spectrum of patients to be served. We cannot expect any one type of institution to handle the whole problem for all kinds of aged persons. What we should expect, however, is that all institutions can work together to actively develop and provide the entire spectrum of services (with the possible exception of many expensive services provided in a general hospital) needed by the growing numbers of elderly persons in this country. They should duplicate efforts in the types of care available if they are to create the network of services which can cope with the mental and physical health problems of this population group. Little by little, actually wasteful duplication will be discovered and avoided, and unproductive overlapping of services can

*A few homes for the aged which have been converted to or have added residential units are discovering that these "apartment projects" cater to an entirely different population than the original home and that, even for them, they must have special managerial, medical, and psychiatric staffs.

be eliminated. At present, old age homes, nursing homes, and State hospitals *all* need X-rays, laboratories, and physicians of internal medicine; State hospitals should be willing to provide life-long care and in-hospital community for relatively full living; all should be geared to be emotionally and psychologically supportive, rehabilitative, and meliorative.

There are a few important points which deserve repetition and emphasis:

(1) The heterogeneous nature of the aged population must be recognized in the planning for health and especially mental health treatment and care. This means that any method of delivering care for any special group or purpose must include readily available accessory services. Depressed aged persons frequently are or become acutely ill; most are impaired or chronically ill; aged persons with organic mental syndrome frequently became transiently, but seriously, paranoid and are commonly continuously or intermittently depressed. Meek aged mentally impaired patients may become depressed, agitated, distractive, and destructive. For all, financial, social and family problems are frequent.

(2) The search for "alternatives" to State hospital care should cease, when this search is prompted by financial considerations as to who (State, local government, Federal government, private resource, insurance companies) should pay for what. If State hospitals are to serve a useful function for the communities they have been created to serve, then they should be expanded and strengthened as medical and psychiatric facilities; the state hospital system should play an important role in providing a complete spectrum of comprehensive health care services. This should range from care in the home, through out-patient care, to a variety of inpatient and protective, prosthetic living arrangements. It should cover all medical, surgical, special medical and psychiatric needs directly or by the quick and easy use of affiliated non-state hospital units.

Instead of "alternatives," *equivalents* may be sought. Under differing auspices, in differing ways, by services at home, in outpatient departments or recreational facilities, by means of residential settings for congregate care, a wide range of services should be available for differing persons with overlapping characteristics. The different systems should be able to give, or be able to make use of, services given by other systems of care; and the type of auspices should not obstruct such cooperation.

A number of different systems providing the same care for persons who arrive for different reasons or by different routes need not mean wasteful duplication of or senseless overlapping of services. For example: a "deranged" hypomanic aged man may reach a general hospital psychiatric ward despite his psychiatric disorder because of incidental, but important somatic problems such as diabetes, hypertension, or glaucoma. Conversely, inadequate examination or different emphasis on what should be primary results in his application for psychiatric hospital care. Both the general hospital and the psychiatric hospital should be ready and able to deal with the entire range of disorders, however intertwined.

After a few months, the patient mentioned earlier could return home, if he has one, or he might be continued in residence in a properly supportive State hospital. Argument "at the gate" of either

hospital as to where he belongs can be fatal for the patient. Each hospital must be equally able to handle the problem at once or to have the full cooperation of the other for immediate admission. Each must be equivalently prepared to find suitable living arrangements for him if he has no home, or has no adequately protective and supportive home at the time when he no longer requires "intensive" medical or psychiatric care.

In sum, populations cared for by differing systems will include similar persons in varying proportions and there will be seemingly similar persons who actually differ in important characteristics. Similarities may be social, medical, psychiatric, physical, cultural, or in chronological age; but the combinations of charactersitics may reveal dissimilarities which account for the difference in "choice" of institution or "disposition" for care. The best educated but most severely brain damaged patients in State hospitals are discovered to be the oldest in years; persons of similarly good education and severity of mental syndrome in old age homes are younger; probably here the use of the State hospital system is on the basis of having used up funds in old age before beginning a search for protective care. Differences in attitudes, incomes, protective persons made for different use of facilities for similar complaints.

All of the factors briefly mentioned here argue for my fundamental points:

—Every type of institution should be prepared to admit persons quickly at a time of crisis;

—All financial obstacles to admission to any type of institution should be removed; and

—All types of institutions should be prepared to render a full range of services.

Institutions may be expected to vary in the size of their "ambulatory mentally well," ambulatory mentally "impaired," physically impaired but "mentally well," physically impaired and mentally impaired, "acutely ill," "chronically ill" mentally impaired, disabled and permanentally ill.

All institutions must be capable of providing adequate service for all types of old persons, if not on a long-term basis, at least until proper disposition can be made.

III. PREVENTION OF MENTAL HEALTH PROBLEMS IN THE ELDERLY

(By Stanley F. Yolles, M.D.)

In order to deal adequately with the prevention of mental health problems in any large population group such as the elderly, it is necessary, first of all, to define what is meant by the term "prevention" and to come to an understanding of the meaning of "mental health" in relation to this group. The broad mission of the National Institute of Mental Health is to maintain and improve the mental health of the nation, and it is in this context that the important problem of the prevention of mental health problems among the elderly will be considered.

In its ideal sense, the term "prevention" implies not only the prevention or avoidance of illness or disease, but also the preservation of

health and the promotion of better health in any group of people. When applied to our older citizens, this demands not only programs to prevent mental illness in later life but that efforts be made to preserve the mental health of individuals as they grow older and that programs be designed and implemented to assist older individuals to function at their maximum capacity throughout their later lives.

The term "mental health" must also be given a broad definition when considered in relation to the older group in our society. In order to understand it in its fullest meaning it must include all aspects which bear upon the personal well-being of older persons, including environmental, economic, sociological, psychological and biological factors which are all of extreme importance to the adjustment of individuals in later life. Activities which may be designed formally and specifically as "mental health" programs are of great importance, of course, but these alone are not sufficient to the task of promoting better mental health in our older population nor of preventing psychological breakdown in later life.

Attention must be paid to some of the factors in our society which exert a negative influence upon the mental health of older people. The first of these has to do with the generally unfavorable attitudes that are held toward aging and the elderly. The handicaps imposed by nonacceptance and loss of status in a youth-oriented society intensify the psychological, emotional, and social difficulties experienced by older individuals. Clarks and Anderson (4) have pointed out the difficult task in adaptation faced by the aging in our society because of the fact that the role of the older individual is ill-defined and ambiguous. Faced with declining physical ability, having lost the status and sense of value that productive employment has provided, having experienced the dissolution of his family structure as children drift away in our mobile society, the older person often is faced with an identity crisis because he has lost the characteristics which are most important to his sense of personal identity and integrity. In a society in which productivity, physical prowess and beauty, and social acceptability are all qualities that are highly valued, it is not surprising that the older individual often begins to doubt his own personal worth, to become certain of his unacceptability to others and literally to "give up." The resultant withdrawal and depression can be treated and improvement often results. However, prevention of such unnecessary emotional suffering would be a much greater contribution to the lives of such individuals. It seems quite ironic that throughout our lives we accept each period of life as preparation for the next; we nurture our children in preparation for adulthood, marriage and parenthood. As parents we look forward to the fruition of our labors when our children themselves achieve successful adulthood. However, we receive very little preparation for later life. Perhaps our educational efforts should emphasize orientation to the complete life cycle so that people do not enter into their later years totally unprepared. The problem involves not only the attitudes of the young toward the old but, more importantly, the attitude of the old toward themselves.

Secondly, it is necessary to understand and accept the dynamic, continuing nature of the aging process. The fact that a person at age 65 has become officially "old" does not mean that aging ceases and that his physical and psychological capacities and problems will remain static and unchanging. The person who at age 65 is healthy

and active will probably experience a continuing diminution of his abilities and activities as he grows older and the "insults of age" increasingly weigh more heavily upon him. The task of prevention is to provide the appropriate physical and psychological supports to compensate for his gradually decreasing abilities. The goal of prevention in this sense is to preserve and enhance the ability of the individual to function at his optimum level; this implies the availability of those services, activities, and supports which can facilitate his functioning and assist him to maintain the greatest possible degree of self-sufficiency and individual responsibility. Walter Beattie(1) has pointed out the need that exists for a "network of services" to which older individuals have easy access and toward which they feel they are entitled by right rather than as a form of charity. The lack of such a network of services is one of the major obstacles to the maintenance of older individuals in a relatively independent manner outside institutions. Fortunately, the need is becoming more widely recognized and perhaps such networks will be established.

A third aspect which should be considered is the need to accept older individuals as constituting an extremely heterogeneous group. Bernice Neugarten(9) has noted that there is no such thing as the "aged" or the "old." There are only aged persons and old people. It is not surprising that this group demonstrates the greatest individuality and heterogeneity of any population group. The individuals comprising it have had a lifetime of experience during which they have formed their own life styles, attitudes, and ways of dealing with themselves and others. It is necessary to keep this in mind when planning any program for older people. All too frequently programs are planned for old people with no provision made for the expression of individual differences within the group. Very often this finds expression in the imposition of a point of view upon older individuals without any attempt being made to determine and make use of the actual opinions and feelings of the older people involved. For example, it has long been held that older individuals do not wish to live with other older persons in age-segregated housing. However, several recent studies indicate that many older people prefer to live with their peers and do not miss the companionship and presence of younger persons except their own children. (Rosow(11), Wilner(14), Hamovitch(7).) Similar questions are being raised about the desire on the part of older individuals to be gainfully employed following retirement. Except in those instances where an older person wishes to continue working because of financial stress, most older individuals look forward to being freed from the demands put upon them by employment. (Hamovitch(7).) The implication is that perhaps some of the attitudes attributed to the aged are not the attitudes that older people themselves hold but rather those that are imposed upon them by others in our society.

Another point that is important in maintaining the sense of values and integrity on the part of the aging is preserving their right and opportunity to make decisions affecting their welfare and behavior to the greatest extent possible. For too long it has been the practice of significant individuals, children, physicians, clergymen, social agencies, to make decisions concerning the lives of older people independent of the individual's ability to decide for himself or his wishes concerning his future. While it is true that in many instances

an older individual is no longer capable of making important decisions concerning himself, this fact should be established before the right is taken away from him and he is denied this most essential mark of his own integrity and self-sufficiency. This observation is supported by the often reported fact of the high incidence of mortality among older individuals who are placed against their wills in institutions. It would seem that this final insult is one that many older individuals find impossible to bear and which results in loss of interest, withdrawal, depression, and eventual death.

There are areas in which progress is being made to maintain the well-being and functioning of the elderly and to prevent breakdown and loss of functioning. Adequate, acceptable housing is an essential need for any older person. A number of efforts are being made in this area with encouraging results. Because of the poor financial status of this group in general, public housing is an extremely important factor. The development of low cost, appropriate housing for older individuals has become a major program of the Department of Housing and Urban Development and at many sites throughout the country housing is being provide for elderly individuals through this program. The effect of this is being studied by several investigators (Wilner (14), Hamovitch(7)), and in several instances the effect of providing on-site social and health services is being studied. (Carey(3), Lawton(8).) Preliminary results from these studies strongly indicate that the provision of adequate housing and appropriate social services provides a very important means of maintaining the physical, psychological, and social well-being of older individuals.

The prevention of unnecessary institutionalization has also received some attention. Rypins and Clark experienced surprising success in finding alternatives to commitment to a state mental hospital for individuals being considered for such placement. Gaitz(6) has demonstrated that screening by an interdisciplinarian team and the provision of adequate medical, social, and psychiatric services can do much to reduce the number of older individuals committed to state mental hospitals.

Prevention must also be a fundamental consideration of programs within institutions which serve the aging. While it is true that there are older individuals who require the specialized facilities of a state mental hospital, a home for the aging, or a nursing home, this does not mean that such placement necessarily denotes the final terminal fate of the individual within the institution. Blancke(2) has dramatically demonstrated that providing active, rehabilitative treatment to older individuals in a state mental hospital enables the large majority of them to return to their own homes or to alternate facilities. This finding has been substantiated by the careful work of Donahue (5). Both of these studies have found that good institutional treatment programs can return older invididuals to the community; the problem that they have identified concerns the lack of appropriate services within the community to maintain such persons outside the hospital. In this instance, prevention would require the establishment of supportive services to maintain such individuals in a relatively independent fashion outside institutions.

The concept of prevention must not be limited to programs outside institutions. If prevention means the maintenance of the optimum functioning ability of the individual, then it has serious implications

for programs within institutions. For example, Reingold and Dobrof-(10) have forcefully demonstrated the value of a productive, commercial sheltered workshop within a home for the aging. Dramatic arrest of behavioral deterioration on the part of individuals who participated in the workshop was demonstrated. This is true even in the case of those individuals who were rated upon psychiatric examination as demonstrating the symptoms of severe mental impairment due to chronic brain syndrome. Ross(12), in his work at Kerrville, Texas, State Hospital has illustrated the rehabilitative effects of placing long-term, chronic mental patients in a socially demanding situation in which the individuals are subjected to the influence of the social pressures of the group and expected to conform to a socially acceptable norm of behavior. In both of these studies, as well as in others, the prevention of behavioral and personal deterioration even when associated with chronic brain disease has been amply demonstrated.

Programs have been established which should be of considerable value in providing services which will be significant in the prevention of mental illness in older individuals. One of the most important of these is the Community Mental Health Center program of the National Institute of Mental Health. The Centers that have been established through this program are designed to provide essential mental health services to all age groups within the catchment area covered by the Center. While the program has not yet been in existence long enough to obtain conclusive statistics, it is anticipated that a wide variety of services will be offered which should be of considerable value in assisting older individuals to deal with the difficult tasks of adaptation to later life. This is but one of the many programs of the NIMH being actively pursued to maintain and improve the mental health of older individuals as but one group of the people of the United States.

REFERENCES

1. Beattie, W.M. "Perspectives on the Changing Characteristics and Needs for Service for Our Aging Population." Testimony presented before the U.S. Senate Special Committee on Aging.
2. Blancke, F., Project Director, NIMH Project No. MHR20–15224, Geriatric Treatment Center, Mendota State Hospital, Madison, Wisconsin.
3. Carey, Jean., Principal Investigator, NIMH Grant No. MHR01–14917, "Senior Advisory Service for Public Housing Tenants", Community Service Society, New York, N.Y.
4. Clarks, M. Margaret., and Anderson, Barbara G. "Culture and Aging", Charles C. Thomas, 1967.
5. Donahue, Wilma., Principal Investigator NIMH Grant No. R01–14894, "Milieu Treatment of Older Mental Patients", University of Michigan.
6. Gaitz, C.M., Project Director, NIMH Grant No. MHR01–14423, "Comprehensive Care of Suspected Mentally Ill Aged", Texas Research Institute of Mental Sciences, Houston.
7. Hamovitch, M.B. "Social and Psychological Factors in Adjustment in a Retirement Village." *The Retirement Process*, Frances M. Carp, ed., Public Health Service Publication No. 1778.
8. Lawton, M.P., Principal Investigator, NIMH Grant No. R01–14923, "Social and Medical Services in Housing for the Aged", Philadelphia Geriatric Center, Philadelphia, Pennsylvania.

9. Neugarten, Bernice L. "The Aged in American Society." In *Selected Papers, Fifth Annual National Conference of State Executives on Aging*. DHEW Office of Aging, OA No. 123.

10. Reingold, J. and Dobrof, Rose. "Sheltered Workshop in a Home for the Aged", *Hospitals*, vol. 38, Sept. 1964.

11. Rosow, I. "Housing and Social Integration of the Aged", Cleveland, Western Reserve University, 1964.

12. Ross, L.W., Project Director, NIMH Project No. MHR20-14975, "Milieu Enrichment in a Geriatric Institution", Kerrville State Hospital, Kerrville, Texas.

13. Rypins, R.F. and Clark, Mary Lou. "A Screening Project for the Geriatric Mentally Ill", *California Medicine*, 109:273–278, Oct. 1968.

14. Wilner, D.M., Principal Investigator NIMH Grant No. MHR011–14881, "Psychological Factors in Housing for the Aged", Reported in Mental Health Program Reports No. 2, Public Health Service Publication No. 1743.

APPENDIXES

Appendix 1

RECENT EVALUATIONS: MENTAL HEALTH CARE AND THE ELDERLY

ITEM 1. INTRODUCTION AND SUMMARY OF RECOMMENDATIONS, EXCERPTED FROM: "TOWARD A PUBLIC POLICY ON MENTAL HEALTH CARE OF THE ELDERLY"

(Formulated by the Committee on Aging of the Group for the Advancement of Psychiatry, November 1970)

INTRODUCTION*

The mental health needs of the elderly have received some attention in recent years, but the substantial additions of funds, personnel, and facilities required to meet those needs have not been forthcoming. Medicare and Medicaid have helped; however, there are severe limitations and major defects in their provisions for mental health.

The potential of comprehensive mental health programs—from home care to institutions—has not been realized. Rather, we find that older patients do not receive early and adequate care in the community but tend to be institutionalized in mental hospitals, nursing homes, and other care facilities with little likelihood of discharge. Furthermore, older patients are being increasingly pushed from inadequate mental institutions into other inadequate custodial facilities, often called "the community." Americans aged 65 and over make up 9.7 percent of our population but account for 25 percent of the annual admissions to mental hospitals. Thus, the elderly suffer disproportionately from our non-system of non-care, characterized by insufficient financing for both health and sickness and by fragmented delivery of services.

Psychopathology in general and depression in particular rises with age. One study by the National Institute of Mental Health (reported by the World Health Organization) shows the following incidence in new cases of psychopathology of all types:

Age range	*New cases per 100,000 population*
Under 15	2. 3
25 to 34	76. 3
35 to 54	93. 0
Over 65	236. 1

*However slow-moving public policy and political actions may be, details change with some rapidity. Where possible this report indicates the dates when certain conditions held. The Report of the Presidential Task Force on Aging will be released soon. There is considerable ferment within the halls of Congress regarding particularly Medicare and Medicaid. We might hope that some of the proposals in this document may have been implemented by the time it is published. We fear, however, that during the publication lag only the language and the arguments will have changed.

Suicide, too, increases with age and attains its zenith in elderly white males. For nonwhite women and men and for white women the curve of suicide is bell-shaped, its greatest height being in the middle years.

There are two groups of older patients in our mental hospitals: (1) those who developed their mental illnesses as a result of old age and its attendant traumata; and (2) those who developed mental illnesses early in life and who grew old in the hospital. As of mid-1963, about 292,000 mentally disordered persons aged 65 and over in the United States resided either in long-term psychiatric inpatient facilities or in nursing homes, geriatric hospitals, homes for the aged, and related facilities. Fifty-seven per cent of these patients were in mental hospitals, 43 per cent in nursing homes and related facilities.

The problems of the aged are extraordinarily enmeshed in the socioeconomic and cultural structure of our society. The need for research and programming is great. Yet in the face of the needs of the elderly and those of other age groups, the administration has proposed a reduction in all activities of the National Institute of Mental Health. The Institute's Research and Hospital Improvement grants as well as those for community mental health centers and training programs have been adversely affected by budgetary considerations.

The H in HEW (Health, Education, and Welfare) has become a casualty of fears of inflation, of high military budgets, and of decisions to commit the American taxpayer's money elsewhere. Research in the field of health—for both old and new studies—has been cut back. Research and service programs in chronic illness have been reduced. The Regional Medical Program (RMP) has been curtailed. Heart, cancer, and stroke programs—barely under way—are losing momentum. Preventive care has not received any significant impetus.

Although some improvement will probably be sought during this election year on behalf of the elderly (for example, drugs under Medicare and an increase in Social Security payments), the Secretary of the Department of Health, Education, and Welfare, before his recent resignation, had made clear his view that attention should turn to children. We believe that the needs of persons of all age groups are the proper concern of any administration.

Although our Nation must commit its great resources to the study and care of children and youth, it is inaccurate to imply that the old receive too much. Eighty-five per cent of the federal expenditures for the elderly are drawn from trust funds into which employers and employees, the elderly themselves, have contributed heavily during their work years.

Our nation should not—and need not—engage in a process similar to battlefield *triage*, deciding to abandon the old and the lame and to support only the young. We believe that the study and understanding of one segment of the life cycle helps in the understanding of the other parts of the cycle, that life is of one piece, to be valued from birth to death. If the old are better off, the young will be less fearful of growing old and less inclined to isolate the aged.

The healthy development of children will lessen but by no means totally prevent emotional problems in old age. Although one's adjustment in old age is influenced by his lifelong personality organization and adaptability, old age has—and always will have—intrinsic special problems. The loss of loved ones and the implacable course of aging are inevitable.

69-261 O - 71 - 11

We believe that understanding the survival traits of old age would help us to effect more successful programs for children in our schools and the larger community.

Those who are professionally concerned about the prospects for the mentally ill aged have a special obligation to speak out on their behalf, for that group is nearly voiceless within the pluralistic system of interests competing for national attention and funds. It is not enough to study and come to understand the problems and potentials of various mental health programs; in the competitive arena of politics one must contend for their implementation.

The basic social and economic status of the elderly affects their mental and social adjustment. Of the 20 million Americans aged 65 and above, nearly seven million are below the poverty line.* Spokesmen for the mentally ill aged must support action to solve problems of income maintenance and housing, as well as proposals concerned with specific mental health issues. Finally, apart from simple justice and humanitarian concern, cultural devaluation of the elderly and the absence of social roles suitable for them adversely affect their mental well-being.

The goal of this report, however, is to examine three basic aspects of the mental health situation for the aged and to offer basic policy recommendations with respect to (1) the nature and quality of services; (2) financial and delivery mechanisms; and (3) training and research.

We offer this report in anticipation of the 1971 White House Conference on Aging.

SUMMARY

In developing a public policy on the mental health care of the elderly we have focused upon three elements: financing and delivery of care, the nature and quality of services, and training and research. We now summarize our specific recommendations:

(1) Universal Prepaid Comprehensive Health Insurance.

(2) Pending adoption of the first recommendation, improvements in the Medicare program:

(a) Elimination of premiums and the present deductible and co-insurance features under Part B;

(b) Inclusion of drugs, dental visits, eyeglasses, and hearing aids;

(c) Coverage of prevention: periodic multiphasic screening examinations;

(d) Coverage of telephone costs, on a doctor's prescription;

(e) Coverage for mental illness at levels comparable to those for physical illness.

(3) Revision of the language of the Long Medicaid Amendment to clarify the intent of the "maintenance of state effort" clause.

(4)(a) In general, elevation and state enforcement of Medicaid standards.

(b) Opposition to any cut-backs in the Medicaid program until it is replaced by an adequate financing mechanism, such as a national prepaid comprehensive health insurance program.

---

*Poverty as defined by reference to the Department of Agriculture emergency food budget of 70 cents per day. Multiplied by 365 days, this totals $255.50. Proposed increases in Social Security and in the minimum payment of $90 per month for the aged will not eliminate the poverty of the elderly.

(5) Support of the right to care and treatment in a wide range of alternative services (the *Lake v. Cameron* case).

(6) Opposition to the movement of older patients primarily for economic reasons, from one facility to another (currently, the movement of patients usually from the public mental hospital to the nursing home, especially for economic reasons). Since mortality increases with relocation, such economies are inimical not only to sound psychiatric practice but to life itself.

(7) Development of comprehensive diagnostic and treatment centers within the sequence of neighborhood health centers, community mental health centers, and hospitals.

(a) Age should not be the critical variable and should not become the basis for segregation.

(b) Two different groups of the elderly must be recognized: one consisting of chronic mental patients who have grown old, the other consisting of elderly persons who have developed a psychiatric illness for the first time in the context of old age.

(c) Pressure on the community mental health centers to provide care for the elderly.

(d) Preparation of a booklet describing the establishment of guidelines for the best comprehensive care—medical, psychiatric, and social—of the elderly patient in a variety of settings: the general physician's office, the psychiatrist's office, the community mental health center, the state hospital, etc. Whether the treatment procedures include individual psychotherapy, group therapy, milieu programs, or whatever, present understanding of the indications and contraindications for each modality should be articulated.

(8) Opposition to separate and large chronic disease and nursing home facilities. Such institutions should be small and part of a complex medical-social institution in which diagnostic and treatment services are available. Custodial care should be elevated to operate within increasingly narrower limits. Standards should be rigorously enforced. Panels of specialists, including mental health personnel, should be available. The prime motivation behind custodial nursing care should not be economic.

(9) All the programs suggested—diagnostic to treatment to personal care workers—should be open to all Americans and not tied to "means tests" that hurt and demean both the middle class and the poor.

(10) Establishment of a National Personal Care Corps with a New Careers Component. Traditional jurisdictional difficulties would be ended with the creation of a jack-of-all-trades who would, through in-service training, move into any of the 125 various health occupations.

(11) Institution of a National Protective Services Program.

(12) Training and education of all the health professions—nursing social work, medicine, occupational therapy, psychiatry, psychology—must include didactic coverage of both the phenomenon of aging and the nature of the elderly.

Health manpower must be increased in number as well as quality.

The National Institute of Mental Health, in particular, should be provided sufficient budget and personnel to take an active catalytic role in effecting changes in education, in community mental health centers, and in other areas.

New kinds of schools for health practitioners are mandatory.

(13) The National Institute of Mental Health and the National Institute of Child Health and Human Development must present more effectively the case of the aging (middle age on) before the various executive branches of the government and before Congress.

(14) Various organizations, including NIMH and NICHHD, and also professional organizations, such as the Gerontological Society and the American Geriatrics Society, as well as the National Council on the Aging, should be encouraged to serve as resource groups to provide data and ideas particular to aging and the aged to the Special Committee on Aging of the U.S. Senate. Specialty groups, including those of psychiatry, social work, and nursing, should be similarly encouraged.

(15) Research monies for studies of aging and the elderly, from basic biological processes to social and psychological phenomena, should be substantially increased. Although one-fourth of all annual admissions to mental hospitals comprise persons aged 65 and over, only 3 per cent of annual NIMH research funds go to the study of aging and the aged. However, the quality of research, not the quantity, is crucial, and new blood and ideas are desperately needed.

(16) The proposal for a Presidential Commission on the Mental Health of the Aging and Retired should be given Congressional mandate. It would afford an opportunity for the various organizations (national and private) and individuals to join together in preparing a body of significant recommendations toward a public policy for the mental health care of the aging.

Although this report has emphasized the assurance of adequate financing and delivery of health care, it is obvious that basic biological and clinical studies must be supported at an increased rate if we are going to be able to improve treatment approaches specific to particular disorders. We already know more than current circumstances allow us to apply. We must remedy this appalling fact promptly. We are suggesting only the basic conditions required to meet humane standards for the dignified care of older people in America. It may be said that one measure of the quality of a culture is its care and respect for its elderly and the extent to which old age may be a consummation of life. This objective is consonant with the perspective of social medicine, of the realization that health and illness, especially in older people, are profoundly influenced by a range of factors in the person and his environment, from individual life history to social and economic circumstances.

ITEM 2. CRITICAL ISSUES FACING THE 1971 WHITE HOUSE CONFERENCE ON AGING

(A report on the Task Force on Aging, American Psychiatric Association, June 24, 1971)

A number of critical issues face the delegates to the White House Conference on Aging scheduled to be held in November 1971. Many

of these issues directly relate to the mental health of aged persons and are by no means new or different from those discussed at other conferences. The Committee on Aging of the American Psychiatric Association has probed some of these same issues for twenty years or longer. A review of the deliberations and reports of the 1961 White House Conference on Aging has revealed that the issues are often the same, and that seemingly little has changed in the past decade.

This should not come as a surprise. Social planners and government officials, give the problem of the aged low priority, but this is not the only explanation. The magnitude of the social and health problems being considered should also be recognized in understanding why the advances made in the last decade or two seem infinitesimal. The aged have increased in actual numbers, and also in proportion, in our growing national population. Adequate care requires a variety and number of services and personnel and consequently the programs are expensive.

The aged represent a target population with a "high risk" for many social and health problems, and they represent a large proportion of those needing help in many areas. This is true whether we are thinking of social problems, such as housing and income maintenance, or health problems such as heart, cancer and stroke. Thus the aged represent a high proportion of the persons in need is apparent whether our approach is age-oriented or problem-oriented.

At the same time, we must recognize that elderly persons comprise a heterogeneous group. There are marked variations in health and socioeconomic status. There are marked variations in the utilization of health services by various ethnic groups just as there are variations in ability of individual aged persons to meet their needs. Chronological age per se may not be most important factor in the development of many social and health problems; yet experience leads us to believe that heavy emphasis needs to be placed on developing programs for the chronologically "aged" because they tend to be neglected when programs for health and social services do not have an age orientation.

A large proportion of elderly persons need assistance to achieve and maintain a full degree of health and well-being. As persons age, there is increased vulnerability and fragility, and paradoxically, the supportive matrix decreases as threats to the organism increases. Aged persons find themselves with fewer personal strengths and assets, less material wealth, and less support from family. The natural environment and the attitudes of society tend to have negative effects on the person as he ages. Maintaining an equilibrium which we might term "health" becomes increasingly difficult, and the person as he ages becomes increasingly dependent on outside resources. His own resources become inadequate to cope with the daily demands of living.

The mental health status of individuals obviously is affected by various socioeconomic factors such as the adequacy of housing, income, recreation facilities, etc. The fact that many elderly persons are living in a state of poverty is another factor to be weighed. The importance of such critical socioeconomic factors cannot be underestimated in the consideration of more specific issues affecting mental health. Socioeconomic forces are constantly at play and therefore environmental manipulation may be more effective in dealing with problems of the aged than with younger persons.

Elderly persons have a variety of social, psychological and health problems. Provision of comprehensive care, therefore, to delineate the

problems and their interrelations, requires a thorough evaluation. An examination limited to a narrow problem area, be it social, psychological or health oriented, results in inadequate appraisal and treatment. Ideally, care programs must be comprehensive and attention must be provided by persons offering specialized care and attention.

Prejudice and stereotyped thinking has resulted in faulty conclusions that treatment programs for the elderly are doomed to fail. Evaluating prognosis, and especially evaluating the effectiveness of treatment, should be dependent on the implementation of a plan which has taken into account the findings of a thorough diagnostic appraisal. When a comprehensive treatment program has been instituted, the results are often quite surprising. At the same time, one must recognize that in dealing with elderly persons, the usual criteria for "improvement" do not always apply. Depending on the status of the individual and the impairments being treated, the therapeutic objective may be maintenance of functional capacity at the current level. Optimal social interaction, and adjustment as measured by accommodation of patient and caregiver may be other criteria one should use in evaluating treatment of elderly patients. Restoration to a functional capacity considered ideal for a young person should not be in the conceptual framework, or at least not the only one, for evaluating effectiveness of care of aged persons.

The wide divergence of interests, capacities, living arrangements, etc., of the aged requires a broad approach in the application of psychiatric principles in treatment programs. Psychiatrists and psychiatrically trained personnel and application of psychiatric theory and skills are required, not only in typical settings providing psychiatric care but also in other settings which do not always acknowledge they are mental health agencies. For example, many persons with psychiatric problems are found in multi-purpose and day care centers, nursing homes and general hospitals. When new programs or communities are being planned, the principles of good psychiatric care should be applied. This principle holds for new and old housing projects, clinics, model city programs, family agencies and others.

Developers of new programs must be careful that they not be seduced by "sloganeering". Community care of the elderly for example, may be a model to strive for, but recognition and meeting the needs of old people should be based on hard data.

An arbitrary administrative decision to exclude elderly patients from admission to state hospitals is a case in point. Certainly some elderly persons *will* become chronic residents, but who can determine the outcome of treatment before it is instituted? Who should treat persons who do *not* have remedial conditions? When the aim of treatment is to attain an optimal level of functioning, then one considers a wide spectrum of services, with some resources in the "community", and others in institutions such as our state mental hospitals. At present, it is quite clear that many elderly persons need institu-

tional care for physical and mental impairment. Philosophically, one may conclude that nursing homes belong to the "community" and state hospitals do not, but the difference is semantic, not a functional distinction. State departments of mental health cannot discharge their overall responsibility without provision of care for some elderly persons who have chronic illness, both physical and mental. The need for supervision of institutions providing "supportive", "rehabilitative" and "maintenance" care of aged persons is obvious and it must be continuous. Persons in these institutions do not need "custody" but rather they need continuous comprehensive care.

Critical Issues

Critical issues may be grouped into two large categories, those dealing with the provision of care and those dealing with attitudes which affect the provision of care. There is much overlap. We shall explore some of the issues by asking relevant questions, attempting to delineate specific issues which deserve attention and sometimes we offer solutions.

1. *What is meant by comprehensive care of the elderly?*

Comprehensive care refers to care which makes provisions for meeting all the needs of a person. The simplicity of this statement is deceptive. Recognizing and satisfying needs are highly complex operations. What constitutes a need? Who is to decide what is needed or how much? Who is responsible for meeting the need? When we began to ask these and related questions, we become aware of the interrelatedness of many factors. Aiming for comprehensive care helps avoid placing undue emphasis on certain aspects of a problem or a situation. It puts pressure on a therapist or social planner to take into account a variety of social, health and psychological factors.

2. *Where should comprehensive care be available?*

Current practices for the delivery of health and social services result in fragmentation and lack of coordination. Services are being provided by a variety of social and health agencies. What can we do about this? How can there be better coordination of effort in general hospitals and nursing homes, mental hospitals and social agencies? What is the role of community mental health centers?

3. *Who is to provide services?*

Administrative responsibility and lines of authority are often hazy. Standards of care and guidelines for the protection of the consumer have been prepared but in practice, these often stifle the practitioner. What level of government is to assume the responsibility for the care of elderly persons? What are the benefits of divided authority? Are there any advantages to continuing current practices of divided responsibility—of having a state's department of health license nursing homes, having welfare departments pay for care in such institutions and having state mental hospitals place patients in such institutions but with only occasional or no supervision? Can we achieve more continuity of care and supervision? If responsibility is not given to a single agency or authority, how can we more precisely designate responsibility, and what techniques can be further developed to evaluate effectiveness of various programs?

Providing psychiatric care in the context of a comprehensive health care program is theoretically logical and possibly ideal. In practice,

however, it sometimes leads to neglect and poor or inadequate care. Mental health programs are treated as a step-child. Therefore, to assure psychiatric care, it usually is necessary to have a program easily identifiable, one which can maintain its own image. Coordinating such programs into comprehensive health programs is possible, and requires special attention to certain aspects, especially financing and training of personnel.

4. *Who is to pay for the services rendered in comprehensive care programs?*

This and related questions can not be separated from many of the other critical issues. Insurance programs, whether they be private or government sponsored, clearly offer the elderly person some protection. Care must be exercised, however, that the provisions and restrictions do not seriously impair therapists. Medicare and Medicaid programs as currently administered, for example, place many restrictions on the availability of psychiatric service. These restrictions are not only in terms of total days coverage for psychiatric illness but other regulations regarding fees further restrict possibilities. Setting a fee of $6–7 for an office visit with a psychiatrist doesn't reduce the cost of the program—it simply results in psychiatrists refusing to see these patients. Another example—a patient admitted to a hospital is eligible for extended care facility benefits only for the primary condition for which he was admitted. A psychiatric patient who develops a condition which would make him eligible if he were not already hospitalized, would have to be discharged and readmitted to a general hospital to become eligible. Provisions enabling preventive care or health maintenance should be included in a comprehensive care program. Payment should be made for periodic examinations, educational programs dealing with diet, health care exercises, etc., might help immeasurably. The potential expense and benefits of such programs probably has not been studied carefully enough, at least not on a large sample. Studies should be undertaken then to determine how expensive a fuller psychiatric program would be as well as the expenses involved in providing more preventive and diagnostic service.

5. *Who is to assume responsibility for elderly persons in need of protection?*

The results of protective service programs have demonstrated the effectiveness of active intervention in the care of elderly persons who no longer are able to care for themselves. Some of these persons have families who for various reasons are unable to do so and many are alone. The legal implications should be given careful consideration and means for effective cooperation with legal authorities facilitated. Possibly guardianship proceedings can be modified so that they are not so expensive and cumbersome. Social and health agencies should be more willing to intervene and take guardianship responsibility for some of their clients.

6. *What legal steps are necessary to provide better care and protection of the aged?*

A reappraisal of Medicare-Medicaid legislation should be undertaken to assure both protection of the consumer and delivery of service which is required. However, programs must be administered flexibly and without rigid adherence to procedures which may not be absolute guarantees of good care. A patient's needs should determine what and how treatment is to be given, not the conditions for reimbursement to a practitioner or institution.

Reappraisal of laws related to protective services also should prove beneficial.

7. *What shall be the role of the state hospital in the future?*

Some of the preceding comments have relevance to this question. For the foreseeable future, it seems quite likely that the percentage of elderly persons requiring institutional care will remain the same, or possibly even increase. Improvement in home care, preventive programs, expansion of senior citizens centers and similar programs may improve the plight of certain elderly persons and contribute to their well-being. A hard core of 4–6% of elderly persons remain who can only be cared for in institutions. At least some of these persons will turn to state mental hospitals. This may be for economic reasons or because certain localities do not have adequate nursing homes, general hospitals and similar institutions. Rather than a total rejection of the state hospitals which have provided care to so many older persons, should we not think in terms of the state hospital as a more enlightened institution, offering a full range of services, adequately staffed and oriented toward offering continued comprehensive care? Do arbitrary regulations setting age limits for admission to state hospitals make sense? Have we accomplished anything if we refuse to admit patients to state hospitals because they will not receive adequate care, and then admit them to other institutions where they are unlikely to receive adequate care? Should not the emphasis be more on development of programs which emphasize good patient care rather than "custody"? Should we not assure that state hospitals become treatment centers and part of a total spectrum of health services? Should we be concerned about the *size* of a state hospital or should we be more concerned about how facilities are being used? Doesn't this same issue, the utilization of a facility, apply equally to nursing homes or facilities which might provide day care, night care or temporary care? If a decision is made to abolish state hospital programs, then what steps should be taken to provide other "geriatric" services to replace them? Does it really make any difference whether patients "sit" in a nursing home or in a state hospital? What seems much more relevant is to assure that patients in institutions receive continuing and comprehensive care and supervision, with opportunities for optimal levels of activity, stimulation and programs which provide for interaction.

8. *What steps can be taken to assure adequate manpower to provide services needed by aged patients?*

Provision of care such as we have been describing is expensive and requires services of personnel with professional attributes to offer special services. Training at different professional levels is essential. Community colleges, nursing home associations, medical societies, including the American Psychiatric Association, and other professional groups must accept responsibility for developing training programs and recruiting additional personnel. Morale of personnel working in mental health programs for the aged face similar problems to those working in any area. Provision of adequate working conditions, opportunities for advancement, respect for the contributions made at all levels of care, assistance with personal problems, adequate attention to issues arising from race and sex roles, etc., are similar by all employee-employer situations. Persons working with aged patients have special problems relating to the chronicity, relatively poor

prognosis and other discouraging and disheartening aspects. How can these persons be helped? What steps can be taken to increase their sense of personal worth? How can one alter deep seated prejudices, stereotyped thinking and other barriers which interfere with recruitment of personnel? How can care for the aged be given higher priority and higher status? How can attitudes within institutions be altered so that the practice of assigning the least competent people to care for the aged be stopped?

9. *Do attitudes toward treatment of the aged affect the development of programs?*

Typically, practitioners are inclined to consider elderly persons as being in a period of rapid decline and deterioration and therefore conclude that any therapeutic approach is likely to produce few results. A more reasonable approach would be to plan the best treatment program possible and evaluate results after a therapeutic trial. Families are accused of "dumping" patients into institutions, especially state hospitals. Studies have shown that families actually are quite attentive to their aged members and that placement in institutions is delayed as long as possible. When "dumping" is suspected, the family members probably are reacting to crisis within the family and the associated problems should be treated rather than for the practitioner to take a hostile, critical stance. Physicians may themselves minimize the stresses imposed on family members caring for dependent elderly family members. They become condescending, react to preconceptions and stand in the way when institutional care, perhaps temporary, would give family members some relief and an opportunity to reappraise the total situation. Families understandably want something done for their sick, aged members. Certain forms of treatment, for example, may be used psychotherapeutically to assure family members that treatment has been undertaken. Programs tend to be too "illness" oriented and practitioners tend to be too nihilistic and negativistic. Day care, temporary hospitalization and other measures may prove quite beneficial and this leads to a reappraisal of attitudes by the practitioner, patient and family. It is important to remember that transportation to and from the facility offering treatment is essential in planning programs. Families, no matter how well motivated, may not be able to provide transportation, and public transportation may be so poor that the elderly person cannot use it. Attention to this matter is often related to the attitudes of the practitioner who expects unreasonably that a patient or his family should be able to deal with this problem of transportation. Public acceptance, especially by those in a position to influence legislation, and support of medical practices, will go a long way to the implementation of good programs.

SUMMARY

No single "system" of care will be applicable to the aged. They comprise a heterogeneous group and programs have to be devised that take into account ethnic differences, impairments, facilities available locally, techniques for on-going care, a program to meet a variety of needs, and a program adaptable to changes in health and social status is needed. High standards of care and expectations should be outlined for all practitioners and institutions, whether they be in the public, non-profit or proprietary sectors. Supervision, probably by state and

federal authorities, as well as peer review techniques, must be continued and yet techniques must be used which assure adequacy of care without stifling the practitioner with unreasonable restrictions. Within any given community there may be duplication of services but this may be desirable because of the need to develop various techniques for the delivery of health and social services. Similarly several types of institutions may be offering similar services and this too may be the best solution, depending on local conditions.

The role of community mental health centers is still unclear but as one of the newest types of institutions, the development of programs in this type of institution should be encouraged. The effectiveness of any approach should be subjected to scrutiny by competent researchers and there should be opportunities for innovation and creativity in either new programs or by the sponsorship of programs already in existence. This relates not only to the provision of care in the usual sense but in developing new techniques for payment. Cooperative efforts with the private and public sectors may lead to more effective utilization of facilties and more return for money invested in care programs.

ITEM 3. PROPOSED RECOMMENDATIONS

(From the American Psychological Association Task Force on Aging, September 1, 1971)

I. Alleged Loss of Intellectual Functioning

Many studies are now showing that the intelligence of older persons as measured is typically underestimated. For the most part, the observed decline in intellectual functioning among the aged is attributable to poor health, social isolation, economic plight, limited education, lowered motivation, or other variables not intrinsically related to the aging process. Where intelligence scores do decline, such change is associated primarily with tasks where speed of response is critical.

RECOMMENDATIONS

Far more attention should be given to understanding and eliminating the unnecessary causes of decline in intellectual function. The absence of intrinsic decline with age should also lead to serious questions concerning the appropriateness of any mandatory retirement age. Functional assessment, advertisement programs, and training in alternative uses of skills at various stages of adult life should be incorporated into work situations. Federal departments such as Labor, Social Rehabilitation Services, and the Office of Education should establish sections with continuing responsibility for proposed and funding research and innovative programs in voluntary retirement, second-career training, leisure-time activity training, and better utilization of skills that do not change with age.

II. Education

It is evident that the majority of aged persons is seriously disadvantaged by past and current educational opportunities. Education

should be conceived of as a continuing, lifelong activity. A more forceful implementation of adult education could do much to avoid not only intellectual deterioration among older persons but also the reduction of conflict between generations.

RECOMMENDATIONS

Some persons need re-training for second careers, many want the enrichment which comes from keeping up with recent advances, others want to raise their career goals, while still others want to develop leisure activities. Still others need educational assistance in the preservation of occupational, self-maintaining, and self-realizing skills. The federal Office of Education should institute a wide range of activities in the fields of adult education and counseling to meet these needs. The widest spectrum of the public and private sector, including state, county, and private educational systems, should develop educational systems for adults throughout the life span.

III. Mental Health

There is a great unmet need for mental health services for the aged. At least three million older persons acquire mental health services. Of this number, a bare 20 percent have their needs met through existing psychiatric facilities. Though people 65 and over constitute 10% of the U.S. population, they comprise only 2% of patients given outpatient mental health services, but 22% of annual mental hospital admissions. Older Americans also tend to have mental and emotional symptoms for long periods of time, often years, before receiving help.

RECOMMENDATIONS

We recommend that federal agencies such as the National Institute of Mental Health pay much more explicit attention to the mental health problems of the elderly, whether in community agencies, comprehensive mental health centers, mental hospitals, or institutions for long-term care. Studies on the prevention and treatment of mental illness need to be accelerated. Alternatives to institutional care must be developed and evaluated for their effectiveness. An intensive research effort is needed to acquire more precise data on the effectiveness of existing services and additional services required to meet the need. In addition, more basic knowledge is required on the causes of specific mental disorders so that primary preventive techniques may be developed to reduce the incidence of mental disorders and their associated disabilities. A Center for the Mental Health of the Aged should be established within the NIMH, with the authority and funds for research, training, and innovative service programs for older people in the community and in hospitals.

IV. Environments for the Elderly

Many of the psychological difficulties of older persons appear to result from lack of environmental supports, rather than from the aging process per se. Inadequate housing, deterioration of older neighborhoods, anti-therapeutic institutions, poorly located services, inade-

quate transportation, and architectural barriers to mobility may act directly upon the emotional and physical state of any vulnerable individual, old or young. Psychological research has shown that improved housing brings new activities and friendships, better access to services provides a new sense of independence and well-being, and an improved community structure yields a heightened feeling of security, particularly for older people.

RECOMMENDATIONS

The federal government has the capability to improve the lives of elderly persons through subsidized programs for better housing, improved institutions, community based service, delivery and leisure-time centers, and transportation systems. Appropriate government agencies such as the Department of Housing and Urban Development and the Department of Transportation, should take responsibility for programs and research for environmental planning needs of the elderly. These departments should play leadership roles in initiating studies of housing, neighborhood planning, and transportation for older people, and in investigating those factors of the physical and social environment that enhance the psychological and social well-being of older persons.

V. Institutions for the Aged

For some older people, the most appropriate place for care is a total custody institution. In contrast to the usual attitude of hopelessness about such patients, research has repeatedly demonstrated the effectiveness of rehabilitative and therapeutic programs in aiding institutionalized aged patients to live more satisfying lives in the institution, and frequently enabling them to return to the community. New community and institutional service networks should be planned and evaluated.

RECOMMENDATIONS

Far more attention needs to be given to the development of innovative therapeutic services to institutionalized older persons. Federal agencies involved with planning and supporting institutional services should assume major responsibility for the dissemination of research knowledge and information regarding innovative programs to potential users. They should also assume responsibility for evaluation of the effectiveness of alternative forms of institutional and non-institutional services.

VI. Professional Manpower and Training

Based upon the most conservative projections of needs and available and future professional manpower it is clear that there is, and will continue to be, a striking shortage of psychologists to serve the public through direct clinical service, to perform basic research, and to educate others.

RECOMMENDATIONS

A minimum 10-year goal is that for every institution of higher learning concerned with graduate education there should be at least one psychologist competent to teach and conduct research on the psychological aspects of aging. It is also clear that we need at least

69-261 O - 71 - 12

several institutions that can function as major centers for teaching, research, and clinical activities with the aging. The magnitude of the problems related to the aging is so great that by 1980 the absolute minimum trained manpower should include 300 new academic psychologists, 600 applied psychologists, and 1200 professional psychologists. Several surveys of manpower needs (see White House Conference Technical Paper on Training, 1971) have made quantitative projections and have documented the acute shortage of trained personnel. The most expert projections, based upon minimal estimates indicate that the above estimate may be less than one-third of the actual requirement for the next decade, and that only 15 of 100 aged persons needing psychological help will be able to obtain it. Only the federal government, with at least a threefold increase in current funding levels for training in gerontology, can provide for these realistic manpower needs.

VII. Research and Demonstration

The value of basic and applied research for extending and improving human lives has been amply demonstrated. Current and future research on aging can be expected to provide information relative to the management of the vital problems of the aged. A few examples are the psychological studies that have made significant contributions to understanding the mental and emotional disorders of aging persons; studies that have led to improvements in treatment and evaluation; studies that have elucidated the factors causing the apparent decline in learning and intelligence; and the social and personality factors that have implications for physical and environmental changes to improve life for older persons. Stereotyped attitudes of the public toward the aged and the negative attitudes of the elderly toward themselves have had detrimental effects on the life style of the aged. Research is needed to determine effective methods of counteracting negative attitudes toward the aging and thereby promoting more constructive use of their skills. Behavioral scientists have information and tools to evaluate the impact of new programs on the feelings, attitudes, morale, and behavior of older persons. Yet, many of the federal programs seek little or no consultation with people who have specialized psychological knowledge relevant to planning.

RECOMMENDATIONS

Research and development in the behavioral sciences is still receiving meager support. It is most ironic that major budget cuts for federally supported research on aging were proposed during the year of the White House Conference on Aging. This pattern must be reversed and programs of basic and applied research in aging given much higher priority. This should be implemented by the creation of a National Institute of Gerontology, to be discussed in the section on Government organization.

VIII. Government Organization

The administrative organization and funding of Federal agencies relating to aging has shown little consistency in function or policy, despite the efforts of individual dedicated staff members. This has produced a public image of a lack of concern on the part of the federal

government for its aging population. The absence of clear policies and stable organizations at the national level has contributed to vacillation and inefficiency on the part of local government, and on the part of institutions which tie their programs into the federal establishment. In addition, the scientific community has had considerable difficulty in finding appropriate sources for funding its research and training.

RECOMMENDATIONS

In order to develop an administrative organization which will help improve the quality of life for older individuals and to maintain an adequate level of research and training support, highest priority should be given to establishing a National Institute of Gerontology within the Department of Health, Education, and Welfare, with assured adequate funding. Programs of other important federal agencies, e.g., the National Institute of Mental Health and the Administration on Aging of the S.R.S., and others previously mentioned, should be strengthened, and would complement those in the Institute. It is also necessary that a special assistant to the White House on Aging be appointed to represent the concerns of older persons. This assistant should have direct access to departmental secretaries regarding their program of services, research and training for the elderly, and the authority to insure their implementation.

ITEM 4. EXCERPT ON "MENTAL HEALTH" FROM "TOWARD A BRIGHTER FUTURE FOR THE ELDERLY"

(The Report of the President's Task Force on the Aging, April 1970)

INTRODUCTION

The Task Force believes that the limitations under Medicare for the treatment of emotional problems constitute an archaic throwback. Because the Task Force sees the resolution of these problems as an integral part of the total health needs of the elderly, it advocates that every possible effort should be made to encourage the use by older persons of available mental health services. To that end it urges that Medicare coverage for the prevention and treatment of emotional difficulties should be reviewed and liberalized. The Task Force further believes that the range of problems associated with the provision of mental health care for the elderly constitutes a major public policy issue which requires positive and innovative Federal direction. Recommendations 13 and 14 relate to mental health care.

RECOMMENDATION 13

Older persons generally are reluctant to avail themselves of services for the treatment of emotional disturbances. They fear that to seek psychiatric help is the first step toward involuntary placement in a State hospital. Even those elderly who might be willing to accept out-patient care are frequently frightened away by the cost. This reluctance is unfortunate because expert opinion suggests: 1) that the incidence of emotional illness is high among older persons; 2) that emotional problems which many older persons regard as a natural

part of growing old can be alleviated through outpatient care; 3) that for many older persons such care would involve only intermittent visits augmented by the knowledge that understanding, sympathy, and help were no farther than a phone call away; and 4) that without such care hospitalization may be unavoidable.

Medicare coverage of outpatient psychiatric treatment—50% of the annual cost or $250 per year, whichever is less—is so limited that it discourages older persons from seeking help and encourages practitioners to hospitalize older persons who may not require hospitalization so that they can receive treatment. Moreover the Task Force believes that the limitation on in-patient care in a psychiatric hospital—190 days during a person's lifetime—for those older persons who experience acute or recurring emotional disturbances is neither humane nor realistic. Nor is it medically sound if it results in the premature transfer of the older person after 190 days of treatment into a custodial care situation. It is also inequitable when compared with Medicare provisions for care of chronic or acute organic illness.

We, therefore, recommend that the restrictions in Medicare coverage on out-patient psychiatric care be removed so that Medicare pays the same benefits for out-patient psychiatric treatment as it does for all other medical care. We further recommend that the 190-day life-time limitation under Medicare for in-patient treatment in a psychiatric hospital be removed.

RECOMMENDATION 14

In addition to examining the relationship of Medicare to the treatment of emotional disturbances of the elderly, the Task Force expressed concern regarding other problems associated with such treatment. These include: the use of State mental hospitals as custodial facilities for large numbers of chronically ill or disabled older persons who are not in need of active psychiatric care because alternative living arrangements with psychiatric consultation or support do not exist; the absence within many State mental hospitals of psychiatric services for those elderly patients who do require such care; indiscriminate regulation against the admission of older patients to public psychiatric facilities; recent trends toward release of elderly patients from State institutions primarily because they are old in the face of the absence of community services to support these released patients; manpower shortages; and the link between adverse social conditions and the incidence of mental illness among the elderly.

Since all levels of government are increasingly active in this area, concentrated attention focused on the development of realistic and appropriate policies seems unwarranted. The Task Force believes that such matters were not adequately dealt with by the Joint Commission on Mental Illness and Health which was active during the late 1950's.

We, therefore, recommend that the President request Congress to authorize the appointment of a Commission on the Mental Health of the Elderly comprised of representatives from concerned Federal agencies, national organizations, Congress, and the judiciary, and private citizens to study, evaluate, and to recommend a comprehensive set of policies for the Federal Government, the several States, and local communities to pursue in this vital area.

Appendix 2

ADDITIONAL MATERIAL

ITEM 1. THE EFFECT OF MEDICARE/MEDICAID ON MENTAL HEALTH SERVICES TO THE ELDERLY[1]

MEDICARE

Hospital Insurance Plan, Part A: Medicare's Hospital Insurance Plan provides benefits toward the cost of inpatient care in a participating psychiatric or general hospital. However, inpatient care in a psychiatric hospital is limited to 190 days during a person's lifetime, as opposed to inpatient care for other illness, which has no lifetime limitation. Moreover, an elderly patient who is admitted to a psychiatric hospital for the first time, if he is beginning a new benefit period [2], can be reimbursed under Medicare for up to 150 days (90 plus 60 lifetime reserve days) in that benefit period. But, in order to obtain reimbursement for the remaining 40 days of inpatient care, he must leave the hospital for 60 consecutive days, and then re-enter the hospital when his new "benefit period" begins.

The "lifetime" restriction of 190 days does not apply to the psychiatric units of general hospitals, where Medicare benefits are the same for patients suffering from mental illness as for those with other illnesses.

If a person becomes a patient in a participating psychiatric hospital sometime before his 65th birthday, for example 30 days preceding his 65th birthday, and remains there or is transferred to a general hospital psychiatric unit, that period of time (30 days) is deducted from his maximum 150 days allowable during his first benefit period, thereby leaving a maximum of only 120 days reimbursable in that benefit period. The patient may still be covered for 70 more days of inpatient psychiatric care, after a lapse of 60 consecutive days outside the hospital, because inpatient days in a psychiatric hospital prior to age 65 are not included in the 190 days lifetime limitation. Furthermore, the deduction for days spent in a psychiatric hospital before age 65 is not applicable when the patient is admitted to a general hospital for diagnosis or treatment of injuries or illnesses that are not primarily psychiatric in nature.

SUPPLEMENTARY MEDICAL INSURANCE; PART B

Part B of Medicare pays 80 percent of the reasonable charges for covered physicians' and other medical services, after a $50 deductible has been met by the patient in each calendar year. However, in the case

[1] All information in this Appendix was abstracted from, "Financing Care of the Mentally Ill under Medicare and Medicaid"—Research Report by Department of Health, Education and Welfare Social Security Administration, Office of Research and Statistics—October 1970—pp 32-84.

[2] A benefit period begins on the first day a person becomes an inpatient in a hospital or an extended care facility and ends when he has not been in any hospital or ECF for 60 consecutive days.

of mental illness, if an individual is not an inpatient of either a psychiatric or general hospital, he is considered an "outpatient", whether the treatment is provided in a physician's office, the patient's home, a nursing home, or outpatient clinic of a hospital. Reimbursement of such outpatient care cannot exceed 50 percent of the expenses for treatment, or $250 in each calendar year, whichever is less. Reimbursement to physicians who provide such "outpatient" care, is limited to $250 a year; no such limitation on reimbursements is set for other illnesses under Part B. The $250 reimbursement limitation does not apply when physicians' services are rendered for medical or psychiatric treatment when the patient is an inpatient, regardless of whether the patient's 150 days benefit period, or 190 days lifetime limit in inpatient psychiatric hospitalization have expired. As noted in a recent report "This circumstance, in view of the restrictions on reimbursement for psychiatric treatment of patients outside the hospital, would seem to encourage hospitalization in the case of needed extended psychiatric services which could perhaps be provided as well or better in an outpatient clinic at less cost to the program." [3]

Community Mental Health Centers.— Those Community Mental Health Centers affiliated with general or psychiatric hospitals that are certified under Medicare, may be reimbursed in the same manner as the hospitals. However, many community mental health centers are independent of hospital affiliation, and are considered "free standing." In order for these "free standing" centers to qualify for Medicare reimbursement (Community Mental Health Centers frequently have a small number of beds for short-term inpatient care), they must first meet the Conditions of Participation for hospitals, as well as the special Conditions of Participation for psychiatric hospitals. These "Conditions" are often inappropriate when applied to Community Mental Health Centers (e.g. autopsy, blood bank, radiology requirements) that are required as part of the Conditions for Participation. Thus, the "free standing" mental health center is excluded from providing inpatient care to Medicare beneficiaries. And, physicians providing inpatient services to Medicare patients in Community Mental Health Centers are subjected to the $250 annual limitation for outpatient psychiatric services given an inpatient by a physician in a general or psychiatric hospital.

These factors may contribute to the low percentage of persons aged 65 and over who utilize services of Community Mental Health Centers in the United States.[4]

MEDICAID

The Long Amendment to the Social Security Act, or title XIX, provides federal participation to States (as of January 1970, 35 States, including the District of Columbia, adopted the mental health provisions of title XIX) to help meet the costs of elderly patients in mental hospitals, when their Medicare benefits are exhausted, or when they are ineligible for Medicare. Also, under this provision, elderly patients in mental hospitals can receive direct assistance payments under title I or XVI of the Social Security Act.

[3] Cited in footnote 1, page 169.
[4] See statistics, report cited in footnote 1.

Federal Requirements for State Participation.—The following requirements of the Long Amendment must be adopted by a State in order to receive Federal Funding under Medicaid for care of patients aged 65 and over in psychiatric hospitals:

a. A joint working agreement between the State agency responsible for the State mental hospitals and the single state agency responsible for the title XIX program.

b. A special staff in the single State agency to oversee the program.

c. Provision of evidence of maintenance of State effort in the funding of mental health services.

d. Show progress toward the development of comprehensive mental health programs through periodic reports.

e. Provision of initial and subsequent periodic medical, social and psychiatric evaluations of each patient participating in the program.

f. Provision and development of alternatives to inpatient hospital care.

g. Patients included in the program must meet the State eligibility requirement for medical assistance.[5]

Maintenance of State Effort

The Maintenance of State Effort clause in Section 1903(b) of the Social Security Act specifies that Federal funds [6] for implementing the provisions for State assistance to aged individuals in psychiatric hospitals shall be paid only to the extent that States make a satisfactory showing to the Secretary of the Department of Health, Education, and Welfare that total expenditures from Federal, State, and local government sources for mental health services for a quarter, exceed average of the total expenditures from such sources for such services for each quarter of the fiscal year 1965. The intent of this clause was to insure that Medicaid money would provide for expanded or new State mental health services.

Most States increased their mental health budgets since the base line year 1965 and thus met the Maintenance of State Effort requirement. In a number of States, however, inflation alone has accounted for much of the increased expenditures, with little or no expansion of services accruing to the patients. Indeed, although the Federal share for vendor payments is transferred by some States to the State mental hospitals and community mental health programs for additional staff and/or improvement of services, such payments in other States go into the general State treasury or a welfare department account, with no equivalent increment reflected in the mental health budget or services of the State. Many of the mental hospitals providing service to Medicaid recipients are required to function within their pre-established yearly allocations regardless of the magnitude of Medicaid reimbursable claims.

A number of States have difficulty in accounting for how, when, and where Medicaid funds were expended on their mental health programs.

Only a few States have initiated data collection systems which enable them to obtain a reasonably accurate picture of the number of

---

[5] In "Financing Care of the Mentally Ill under Medicare and Medicaid" pp 78-79—cited in Footnote 1.
[6] Cited in Footnote 5.

patients in their programs, type of care provided to the individual patient, status of periodic reviews, and reimbursements collected. Indeed, the recent Report of the Task Force on Medicaid and Related Programs addresses itself repeatedly to the need for increased effectiveness in the total Medicaid program, e.g., noting that ". . . to the best of our knowledge no State has yet established an effective system of reviewing and controlling utilization from the standpoint of appropriateness, quality or timeliness of service." [7] Hence, there should be "National minimum requirements for claims review, fiscal control, utilization control and other review and evaluation, including determination of patient and vendor eligibility; how costs and charges relate to ranges established by agency policy." [8] In addition, Section 232 (a)(3)(ApB) of H.R. 17550 provides strong incentives for the States to implement mechanized claims processing and information retrieval systems compatible with those utilized in the administration of Title XIX. Presumably, the claims processing component of these systems would insure that a definite relationship between billing and actual care received by the patient does exist."

Other services included in the treatment of the mentally ill under Medicaid are: [9]

1. Inpatient hospital care—in psychiatric ward of general hospitals.
2. Outpatient care and services—treatment in mental hygiene outpatient clinics, such as community mental health centers, which are operated by qualified general and/or psychiatric hospitals.
3. Physicians services—including diagnosis, evaluation and treatment by psychiatrists.
4. Skilled nursing home services—required service for those over 21, optional for those under age 21.
5. Other laboratory and X-ray services.
6. Clinic services—optional service, which has been adopted by 30 States and the District of Columbia which includes "free standing" mental hygiene clinics and community mental health centers.
7. Prescribed Drugs—a State option covering medications, including psychotropic drugs.

ITEM 2. PROGRAMS OF THE NATIONAL INSTITUTE OF MENTAL HEALTH [1] RELEVANT TO THE MENTAL HEALTH OF THE AGING

The mandate given the National Institute of Mental Health by the Congress is to maintain and improve the mental health of the people of the United States. Within this broad mandate, the mental health problems of older individuals are of particular interest to the institute. Hardly a person in this country remains untouched by

[7] As of October 1970, at least two States have implemented such a program.

[8] Report of the Task Force on Medicaid and Related Programs, U.S. Department of Health, Education, and Welfare. Government Printing Office, Washington, D.C. 1970, page 41, 42.

[9] The first five services listed are required by law for the categorically needy in a State Title XIX plan.

[1] Provided by Thomas E. Anderson, Ph.D., Chief, Section on Mental Health of the Aging, Division of Social Mental Health Programs, National Institute of Mental Health, Department of Health Education and Welfare—January 1971.

the plight of an older person who is either a relative, friend, or neighbor, with some chronic illness, frequently in combination with a degree of mental disability. Given these present facts and future projections, it is appropriate that the mental health aspects of aging are among the prominent areas of scientific inquiry supported by the NIMH. While medical science has increased life expectancy, the complexities of modern life such as urbanization, automation, and new developments in knowledge and technology pose difficult problems in adaptation for older persons. The intricate and complex relationships existing between the individual's life style, his emotional state, his intellectual processes, and the effects of biological aging provide an interesting and challenging area for study and service on the part of researchers and clinicians in the field of mental health. In addition to having many of the mental health problems common to other age groups, older people are vulnerable to specific difficulties associated with the aging process. Although some of the impairment of the aged is part of physical aging, psychological reactions to the physical process engender excess impairment that cannot be attributed to organic change. For example, the high incidence of depression, suicide, withdrawal, and regressive responses on the part of older people demands attention by those skilled in the mental health professions.

The NIMH makes use of a wide variety of program mechanisms to carry out its mission. For practical purposes the activities of the Institute can be categorized in three main areas: research, services, and training.

Research: Research aimed at providing new knowledge and a greater understanding of the factors involved in the development of psychiatric illnesses in later life and their prevention has traditionally been one of the most important endeavors of the NIMH. The Institute supports a wide range of research related to the aged and the aging process involving the biological, medical, psychological, and social sciences. These studies range from research undertaken to discover and elucidate the basic biological processes involved in aging to applied research projects designed to establish and evaluate new methods of providing mental health services to older people. While much knowledge has been accumulated as a result of this program, much more remains to be done.

Services: Two major service programs of the Institute can be readily identified and described. The first of these is the Hospital Improvement Grants program which provides grants to State mental hospitals throughout the United States for the improvement of their services to patients. The hospitals that apply for this program identify a particular area of need within the hospital and use the funds to raise the level of care and improve the treatment program offered the patient. At this time, 18 of these projects are specifically directed toward the geriatric population in State hospitals. In these programs, it is typical that close attention is paid to milieu therapy and to remotivation programs. Attempts are made to involve family and friends of the patient and to bring about stronger relations between the hospital and agencies in the community. Several projects include preadmission screening and referral programs; others incorporate supportive followup services. Some projects address themselves to

specific segments of the geriatric population, such as severely debilitated patients requiring considerable nursing care, chronic patients who have been long institutionalized, recent geriatric admissions, and patients showing the best chance of living independently outside the hospital. This program encourages the use of current knowledge for demonstrations of improved treatment and rehabilitation programs and services. One common thread runs through all of the most successful projects in this program: that of insisting upon the individuality and identity of each patient and of encouraging his self-sufficiency and sense of personal integrity.

The other major service program of the NIMH is the Community Mental Health Centers program. In this program, funds can be provided to communities for the construction and staffing of community mental health centers. Each center is responsible for all the individuals living within its catchment area and must provide five basic services: inpatient and outpatient services, partial hospitalization, emergency services, and consultation and education. Since the enactment of the Community Mental Health Centers Act in 1963, 165 centers have been established throughout the country. Three hundred fifty-seven have been funded as of December 31, 1968. The established centers are serving their communities in cooperation with many agencies and community groups.

These centers should provide a major resource for the community treatment of older individuals. Since these centers are responsible for the entire population of the catchment area, older individuals in those areas are entitled to the services offered by the center, and they thus provide a new resource previously unavailable to many older persons in the population.

Training. The essential element required in all the research and service endeavors mentioned previously is adequate personnel, both in numbers and in training. The Division of Manpower and Training of NIMH has as its function the support of training for individuals in the mental health professions including psychiatry, clinical psychology, social work, and nursing. In addition, grants are available for training in public health, in the biological sciences, and in the social sciences for mental health professionals. Development of new and experimental methods of training is encouraged and a program of continuing education is also supported.

ITEM 3. VETERANS ADMINISTRATION PROGRAMS FOR THE ELDERLY MENTALLY ILL

VETERANS ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., October 7, 1971.

DEAR MR. CHAIRMAN: I am pleased to provide the following information you requested for the Appendix of your report on "Mental Health and the Elderly: Shortcomings in Public Policy."

Following the completion of the pilot project, "The Patient Returns to the Community," [1] as described in Veterans Administration's Pamphlet 10–83, the program was recommended to all VA hospitals. A survey showed that at the end of FY 71, one hundred and sixteen

---

[1] A voluntary Service Program in the Community.

hospitals have initiated variations of the program. A number of hospitals without volunteers for this program reported their patients in community care were receiving services from volunteers under other auspices than the VA Volunteer Service Program. During the fiscal year, 1,172 volunteers were recruited for work in the Community Care Program. At the end of FY 71, 990 were still actively engaged in providing services.

The reporting hospitals described a wide variety of activities provided by the volunteer. In the psychiatric hospitals, the typical volunteer services consisted of helping patients participate in community activities and assisting Social Work Service in locating foster homes. In the general medical and surgical hospitals, the most frequent community assignment for volunteers was visiting patients in nursing homes. Experience with the volunteers prompted the development of VA Information Bulletin 11–1, *Community Service Volunteers*.

A recognized and essential element in the utilization of volunteers in the community is a well developed training program for them. Forty-eight hospitals have reported the development of Social Work Service Volunteer Development Programs. An average of five to six hours per volunteer is needed for training purposes.

VA Form 10–1352, Referral to Community Service Volunteers, has been developed for the social worker's use in making referrals to the volunteer for services to veterans who have returned to community living. A viable communication network between the social worker and the volunteer is essential. The social worker and individual work out a mutually agreeable two-way communication plan, which may include periodic conferences, telephone calls and written reports. Written reports from the volunteer are acknowledged by the social worker. The needs of the patient and his new life in the community are at the core of this activity by the social worker and the volunteer.

Community Education is a continuing process. The community service volunteer, is in a position to effectively interpret the goals of the hospital for the patient, to their own organizations as well as other groups. This is an effective means for the marshalling of community resources for the individual patient. Social workers maintain liaison with the range of health and welfare organizations from the local to the state levels. They are in a position to clarify the mission of the hospitals and the needs of patient groups to the health and welfare community.

Another means of community education is the joining together with other pertinent organizations around major issues. An example of this is the whole area of protective services. The enclosed report of the "Third Annual Social Work Service Institute," held February 26–27, 1968, VA Hospital, Miami, Florida, demonstrates how public, private and voluntary agencies can bring to bear, their combined expertise and concerns in a major problem area.

Another means for community education is through VA research and the subsequent publication of the findings. The publication of research findings are widely used for improving professional practices, teaching purposes and a continuing growth in the body of knowledge used by professional staffs. Following are three reprints of research efforts that have been published.

"Patient Perceptions of Nursing Home Placements," Robert J. Maroney, Ph. D., Lee Gurel, Ph. D., John E. Davis, Jr., Ph. D., *Geriatrics*, June, 1969.

"Initial Reactions to Nursing Home Placement," Margaret W. Linn, MSSW, Lee Gurel, Ph. D., *Journal of the American Geriatrics Society*, February, 1969.

"Wives Attitudes Toward Nursing Homes," Margaret W. Linn, MSSW, Lee Gurel, Ph. D., *Journal of Gerontology*, July, 1969.

Financial assistance is of a temporary nature and usually comes from the organizational treasury of a veterans organization. Each hospital has a General Post Fund which is funded by the donations from service organizations. The money is for temporary emergencies befalling the veteran or his family.

There is no one project that shows more promise than another. Our effort has been directed toward developing a wide range of community resources to meet the varying needs of veterans. Thus, we have a variety of living situations which encompass close family living such as in the foster home; the half-way house which is a transitional living situation between the hospital and independent living in the community; and the nursing home for those needing this level of care. Every effort is made to help the veteran select the most appropriate living situation for his medical and social needs. A major cornerstone of the community care program is the return to a VA hospital if the veteran develops an actue illness again requiring hospital care and treatment.

Probably the major deficiency in any community care program rests on several pivotal resources: The continuing need to develop community living situations over a broad front to meet the varied nuances of medical and social needs; the manpower to locate and develop resources and to provide the follow-up after the individual returns to the community; and, the money to pay for care.

In FY 67, 68, and 69 a total of 60,712 patients (all ages) were placed in community care placements from VA hospitals. This can be broken down to show that 42,553 came from general medical and surgical hospitals, while 18,159 were placed from psychiatric hospitals.[2]

When the age factor is examined the following placements and percentages show the differences between the psychiatric and the general medical hospitals. In general, most of the psychiatric patients under age 60, will be placed in a setting other than a nursing home. In contrast, over half of the general medical and surgical patients will have been placed in nursing homes.

PATIENTS PLACED BY AGE GROUPS IN PSYCHIATRIC HOSPITALS

	Under 40		40 to 59		60 and over	
	Number	Percent	Number	Percent	Number	Percent
Fiscal year:						
1967	388	20.9	1,211	65.3	254	13.8
1968	427	20.2	1,331	63.1	352	16.7
1969	456	20.5	1,402	63.3	356	16.1
1970	403	16.1	1,696	67.8	402	16.1
1971	467	18.7	1,610	64.6	416	16.7

[2] In FY 70, 17,135 patients came from general medical and surgical hospitals; and 7,730 psychiatric patients were placed in the community.

PATIENTS PLACED BY AGE GROUPS, GENERAL MEDICAL AND SURGICAL HOSPITALS

	Under 40		40 to 49		50 to 59		60 to 69		70 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Fiscal year:										
1967	364	2.8	1,104	8.4	1,773	13.6	2,525	19.4	7,287	55.8
1968	399	3.0	1,228	9.1	1,904	14.1	2,347	17.5	7,570	56.3
1969	465	2.9	1,492	9.3	2,394	14.9	2,715	16.9	8,986	56.0
1970	611	3.6	1,702	9.9	2,866	16.7	3,164	18.5	8,792	51.3
1971	585	3.6	1,582	9.8	2,837	17.6	2,870	17.9	212	51.1

In FY 71, there was a total of 38,988 patients in community care placements. There were 2,057 volunteers providing services to these patients. There are 200 full time social workers assigned to community care. This is the staff that locates, develops the placement settings, places and provides the follow-up services to the patients.

On March 15, 1971, there were 76 nursing care units in VA hospitals with a total of 5,155 beds. These units are distributed throughout the nation and each unit serves as a resource for several other VA hospitals.

I hope the above information will be of use to you in developing your report.

Sincerely yours,

M. J. MUSSER, M.D.,
Chief Medical Director.

ITEM 4. A REVIEW OF THE IMPACT OF THE COMMUNITY MENTAL HEALTH CENTER MOVEMENT ON PSYCHIATRIC SERVICES TO SENIOR CITIZENS

(By Robert H. Dovenmuehle, M.D., executive director, Dallas County Mental Health and Mental Retardation Center, Dallas, Texas)

In concept, a great advance has taken place in health care since the last White House Conference on Aging was held in 1961. In terms of implementation, the Comprehensive Community Mental Health Center Act definitely put mental health in the lead. With the federal government establishing and subsidizing a system of health care based on the mission of total care of the mental health needs of a geographically defined population, one could reasonably expect that the elderly population with its high percentage of psychiatric problems would be well represented in center populations. Under the auspices of the Senate Special Committee on Aging, a questionnaire was sent to the 222 operational centers in order to obtain information relative to this point.* The questionnaire was modified from one devised by Dovenmuehle and Shanas (for a survey of OEO Health Centers in early 1969) under the same auspices.

One hundred and thirty-four questionnaires were returned by the deadline set for the compilation of results. There was a great deal of variability in information available since many of the items were left blank. A few of the centers described a catchment population that was large enough to contain more than one catchment area and some did not report the population of their catchment area. One hundred and fifteen centers reported a total catchment population of 19,435,973 persons of whom 11.81% were 65 or over. Most of these data were based on the 1960 census although some were more recent.

*—1970.

Of a total of 162,552 new cases registered during the previous year (and some centers had been in operation for lesser periods of time), 4.76% of the cases were 65 or over. With respect to new admissions over 65, the range of response was 0 to 33.3% with the mean being 4.76% and the median 3.5%. Of the 105 centers reporting on elderly new admissions, 8 (7.6%) reported a percentage of new elderly patients equal to or greater than the percentage of this age group in their respective communities.

During the same period of time, information was requested relative to cases closed by transfer to long-term care facilities. Only 71 centers reported this information. In these centers, a total of 14,396 cases were closed in this manner with 19.10% being 65 or over. This means that although new cases 65 and over represented less than half of that population in the community, proportionately a much greater percentage were terminated by transfer to long-term care facilities.

Of 129 centers responding to a question concerning patient service priorities, 86 responded that they had none and 43 responded that they did have selected priorities. Of those responding yes, most of the stated priorities related to emergency or crisis services. Services to catchment area residents and children's services were frequently mentioned. Two of the yes respondents indicated the aged as a priority concern.

In response to a question regarding specialized service for the elderly, 97 indicated there were none and 34 indicated that these were available. The range of specialized services included liaison with special inpatient facilities nearby, consultation to established senior citizen agencies, a number of direct service groups devoted to the needs of elderly people, partial hospitalization programs, and screening programs. By far the most frequently mentioned direct services were partial hospitalization and therapy groups.

Asked to comment on whether specialized services for the elderly was a good or bad idea, 29 responded no and 93 responded yes. In commenting on this question, most of the centers indicated that it would improve services to a specific high-risk group. Some of the centers have been active in planning for such services because of the concentration of retired persons in their vicinity. Many commented on the fact that such programs are not now available to the elderly in their area and that the general service program tends to be underutilized by the older person.

Of those centers who felt that it was a bad idea to have such specialized services, most pointed to the fact that there are few persons in this age group at their center and also that it is not the intent of their center to provide specialized services in any area. Many pointed to the cost of developing specialized services as prohibitive in their setting.

As part of the questionnaire, we asked how many people age 60 and older were on the payroll, whether part or full-time, as of May 31, 1970. The intent of this question was to determine whether or not the factor of age of employed personnel may have an impact on program. Although not completely analyzed, the summary of the data indicates that of 10,640 personnel employed by 125 centers, 3.5% of these were 60 or over. Many centers, of course, had no employees in that age range and one center had only one employee who was 60 or over.

A related concern was whether or not center staffs had full or part-time professionals employed with geriatric psychiatry as a special interest. With respect to psychiatrists, 106 centers did not, 12 centers had full-time employees in this category, and 5 part-time. With respect to social workers, 104 centers reported none, 13 full-time, and 4 part-time.

When asked if they would like to have personnel specialized in this area, 25 centers reported no and 98 yes. Asked to render an opinion as to whether or not they felt that addition of trained personnel to the staff would improve their operation, those answering yes indicated generally that they felt it would improve services to many members of the catchment area, but indicated the difficulties in finding professionals trained and interested in that area. Many indicated that as part of staff training, it would be helpful to the overall objective of the center. Of those responding no, many indicated the lack of demand in their particular centers for such services and several comments indicated disagreement on specialization on philosophical grounds.

Asked if training and consultation were available, would they be interested in developing or improving services to the aged, 119 reported yes and 12 no.

SUMMARY

It is clear that in most of the Comprehensive Community Mental Health Centers, problems of the aged are not being adequately reached. The fact that few personnel have any special interest in this age group appears to be a very important factor in this since most of the centers indicated that they would like to have specialized programs and specialized personnel.

It seems clear that training for community mental health center personnel in geriatric psychiatry is both wanted and needed. It is recommended that one of the proposals before the White House Conference on Aging should be an intensive program to train mental health center personnel in the care of the aged.

ITEM 5. STATEMENT BY THE HON. EDMUND S. MUSKIE, IN SUPPORT OF APPROPRIATIONS FOR STAFFING OF COMMUNITY MENTAL HEALTH CENTERS (JUNE 22, 1970—BEFORE LABOR-HEW SUBCOMMITTEE OF THE SENATE APPROPRIATIONS COMMITTEE)

Mr. Chairman, I come before you today as a member of the U.S. Senate Committee on Aging and Chairman of the Subcommittee on Health of the Elderly to testify on the low level of funding being requested for the staffing of Community Mental Health Centers.

The Administration is requesting $60,100,000 for staffing grants to Community Mental Health Centers in 1971. This represents an increase of $12,550,000 over the 1970 estimate.

However, these figures are deceiving. Because of the low level of funding appropriated to Community Mental Health Centers in 1970, the National Institutes of Mental Health has informed the Committee on Aging that they now have $20,000,000 more approved applications for staffing grants than they can fund.

Mr. Chairman, the Community Mental Health Centers are operating in the red and they will continue to do so if more funds are not allocated. All the proposed $60,100,000 will provide is for continuation grants to those Centers with staffing grants already in operation.

No funds have been proposed for new projects.

The effect of this deficit on the elderly in this Nation who are suffering from varying degrees of mental disorder will be, I am afraid, indicative of neglect and indifference.

When Federal or State money is tight, programs for the elderly are traditionally shunted to the bottom of the priority list.

Consider this fact: of the 165 Centers now in operation throughout the country, only 30 have special geriatric programs. It is safe to assume that the elderly are already on the low end of the priority ladder in Community Mental Health programs.

This may be true because it is notoriously difficult to recruit trained professionals to work with older mentally ill individuals. The "cure" is less dramatic; the treatment of an older person makes heavy demands on the time and patience of workers and therapeutic gains are usually smaller; and the mental illness is often complicated by chronic physical ailments.

In short, it takes time to discover what is troubling an older person. Perhaps he is hard of hearing and the psychiatrist has to repeat his questions many times; his so-called "hallucinations" may in fact be due to an advanced state of undetected diabetes; or his "wanderings" and loss of memory may be the result of brain damage caused by a stroke.

Obviously, specialized treatment programs are necessary for these older patients. Some already in practice in the 30 Centers with geriatric programs include: sheltered workshops to provide the older patient with a sense of usefulness and worth, coordinated medical and psychiatric treatment in order to determine the degree of actual "mental" illness and the extent of physical illness, and intensive outreach services to find the mentally impaired older citizens in the community and make them aware of this service.

Outreach is possibly the most important component of any service program for the elderly—but is especially so in aiding those with mental disorders.

Recent studies indicate that the elderly may be less likely to make use of Community Mental Health Centers than are younger persons. The National Institute of Mental Health reports that anywhere from 15 to 25 percent of elderly persons living in their own residences have some degree of mental disorder and that a minimum of 8 percent of these individuals are known to be severely disturbed. And yet, the number of aged persons using outpatient psychiatric clinic services is only 2 percent of the overall population. There are some good reasons for this underutilization. First, older people are frightened and embarrassed at the thought of being treated for mental problems. Second, many—especially the poor and the isolated—are unaware that the services exist. And third, the same problems keep older people from taking advantage of these services that keep them from participating in other social services: lack of income and poor transportation facilities. Even if a person knows of the availability of a particular service; if he has no money or facilities to get him to the clinic, the service is useless.

Finally, of course, we come to the question of staffing. Let us assume for the moment, Mr. Chairman, that I am an older person who has shown evidence of mental disorder. My family or friends have directed me to the local community mental health center. I go to the center

and wait for perhaps hours for an appointment with a psychiatrist or psychiatric social worker who has no knowledge of geriatric psychiatry, and who is overworked because the center is understaffed. After a cursory examination, the professional decides that there is nothing he can do except perhaps to prescribe tranquilizers for my "depression" as I am, in his thinking, hopelessly "senile." He does not ask me about my eating habits; he does not ask me whether I have any social contacts; he does not ask where I live, whether it is a walk-up flat, alone or with family; or about my physical condition, nor does anyone else at the center examine me for physical ailments. This is not due to unfeeling negligence on the part of the staff. It happens all across this country, in every outpatient psychiatric clinic or mental health center where there is not a specialized geriatric program simply because no one on the staff is trained to work with older people.

And so, getting back to my role as the elderly patient, I leave the Center discouraged, humiliated at the cursory treatment, and without having my problem alleviated. I am not about to go back to that Center when my condition worsens. I am more than likely going to end up in a State mental hospital or a nursing home, costing the State and Federal Government many thousands of dollars.

There is another situation we must consider when discussing the mentally disturbed elderly population. Most State mental hospitals have in the past ten years, stopped the practice of "dumping" older patients into back wards to languish with no care for years. They have made great efforts to rehabilitate these patients and get them back into the "community." This is certainly admirable but let us consider what the "community" means to an older person who has spent years in a mental hospital.

Because there is often no place in the outside community where an older mental patient can continue his rehabilitative treatment, to him the "community" means a nursing home where he more than likely receives "custodial" care—that is, no care. Thus, all of the rehabilitative efforts by the State hospital are wasted and the patient finds himself, in effect, in another "back ward."

If this sounds far-fetched, let me read you some illuminating statistics. The National Institute of Mental Health estimates that 55% of the residents in nursing homes and related facilities serving the chronically ill are mentally impaired. In researching a forthcoming report on Mental Health and the Elderly, the Committee on Aging staff found that this may well be a conservative estimate. When asked by the staff for the number of mentally impaired persons residing in their facilities, six admittedly enlightened nursing home administrators replied that at least 75% of the patient population was mentally impaired to some degree and that 25–40% were severely disturbed.

Many of these people could be treated in the community—if there were facilities in the community to treat them.

The Community Mental Health Centers were meant to be just such facilities. If the Centers were adequately staffed with trained personnel, thousands of Federal and State dollars could be saved in institutional care alone. Not to mention the hundreds of thousands of individuals—young and old—who could be saved from the agony of mental illness.

69-261 O - 71 - 13

When I talk about saving the State and Federal Government thousands of dollars, it is not wishful thinking. The most recent estimated cost of mental illness in the United States—1963—was $7 billion of the total cost of all illness. More than $2 billion was spent directly for hospital and physician services and the remaining $5 billion represents estimated economic losses in productivity of persons who died or became disabled as a result of mental illness.

As of mid-1963 in the United States, about 292,000 persons aged 65 and over with mental disorders were residents in long stay institutions; state mental hospitals, homes for the aged, nursing homes and convalescent hospitals. The only place that number has decreased has been the State mental hospital (with approximately 118,000 aged residents in 1968). All other long-stay facilities have increased their mentally ill aged population, as my earlier remarks illustrate.

The fact remains that the State and Federal Governments are still providing expensive institutional care for a great many elderly persons, many of whom could be cared for while living in their own residences if there were adequately staffed Community Mental Health Centers to assist them.

When are we going to realize that half-way measures and sporadic funding does nothing to help such matters. Indeed, this practice may make the problem worse. Because when we build Community Mental Health Centers and then do not staff them adequately what we have really done is build useless edifices as a tribute of our concern for the mentally ill.

The mentally ill of this Nation do not need "monuments" to their leaders concern; they desperately need help, treatment and care.

Although I speak on behalf of the elderly, let us not forget that this limited funding will affect all age groups.

The Administration proposal calls for no new projects for 1971. The meaning is clear—no new services for the elderly, children, teenagers, young mothers or workingmen.

When we consider the mounting stress of day-to-day living in our society today, we cannot afford to deny the care we have promised to any segment of this society.

Therefore, Mr. Chairman, I urge you to raise the level of funding for staffing of Community Mental Health Centers at least so that the NIMH may accept the $20,000,000 worth of approved applications for staffing grants that they now have—and develop new projects for older Americans and others who may be suffering from mental disorders.

Only then will the Community Mental Health Centers Act be properly implemented.

Appendix 3

GLOSSARY OF TERMS

GLOSSARY*

Agitated Depression.—A psychotic depression accompanied by constant restlessness. Sometimes seen in involutional melancholia.

Organic Brain Syndrome.—A disorder caused by or associated with impairment of brain tissue function. It may be manifested by disorientation, loss of memory, and impairment of the ability to learn, comprehend, calculate, and exercise judgment. May be psychotic or nonpsychotic, mild, moderate, or severe.

Acute Brain Syndrome.—An organic brain syndrome in which brain damage is temporary and the brain pathology and its accompanying organic brain syndrome is reversible.

Chronic Brain Syndrome.—An organic brain syndrome in which brain damage is permanent and the brain pathology and its accompanying organic brain syndrome is not reversible.

Cerebral Arteriosclerosis (*Arteriosclerotic Brain Syndrome*).—Hardening of the arteries of the brain resulting in an organic brain syndrome. Cerebral arteriosclerosis typically manifests itself in people over 50 years of age and at the present time accounts for approximately one-fifth of all first admissions to mental hospitals.

Mental Disorders.—Any psychiatric illness or disease included in the World Health Organization's *International Classification of Diseases,* or in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* 2nd ed., 1968. Many of these disorders are defined in this glossary.

Speech Disturbance.—Any disorder of verbal communication that is not due to faulty innervation of the speech muscles or organs of articulation.

Aphasia.—Inability to utter a sound, word, or phrase or to find the right name for an object. Sensory aphasia: inability to perceive or understand certain sounds, syllables, or phrases, as in word-blindness. Central or syntactical aphasia: speech is fluent but disordered by verbal and grammatical confusions (paraphasia).

Day Treatment Center or Day Care Center.—See PARTIAL HOSPITALIZATION.

Catchment Area.—In psychiatry, a term borrowed from the English to delineate geographic area for which a mental health facility has responsibility.

Dependency.—Vital need for mothering, love, affection, shelter, protection, security, food, and warmth. May be a manifestation of regression when need reappears openly in adults.

Depression.—A morbid sadness, dejection, or melancholy. To be differentiated from grief which is realistic and proportionate to what has been lost. A depression may be a symptom of any psychiatric

* Prepared for this study by the National Institute of Mental Health.

disorder or may constitute its principal manifestation. Neurotic depressions are differentiated from psychotic depressions in that they do not involve loss of capacity for reality testing. The major psychotic depressions include psychotic depressive reaction and the various major affective disorders.

Deterioration.—Worsening of a clinical condition, usually expressed as progressive impairment of function; in organic brain syndrome, for example, deterioration refers to a progressive loss of intellectual faculties without implying permanency of change.

Disorientation.—Loss of awareness of the position of the self in relation to space, time, or other persons; confusion.

Group Psychotherapy.—Application of psychotherapeutic techniques to a group, including utilization of interactions of members of the group.

Group Social Work.—Recreational, social, education, and cultural activities to further the satisfactions and growth of participating group members by providing positive experiences through group activity programs, interaction with other group members, and interaction of the group with the community. The trained group worker is skilled and knowledgeable in individual and group behavior and community relations. Also called "social group work." Not to be confused with group psychotherapy.

Halfway House.—In psychiatry, a specialized residence for mental patients who do not require full hospitalization but who need an intermediate degree of protection and support before returning to fully independent community living.

Milieu Therapy.—Literally, treatment by environment in a hospital setting. Physical surroundings, equipment, and staff attitudes are structured in such a way as to enhance the effectiveness of other therapies, and foster the patient's rehabilitation.

Partial Hospitalization.—A psychiatric treatment program for patients who require hospitalization but not on a full-time basis. For example:

> day hospital—a special facility or an arrangement within a hospital setting that enables the patient to come to the hospital for treatment during the day and return home at night.
>
> night hospital—a hospital or hospital service for patients who are able to work or otherwise function in the community during the day but who require specialized treatment and supervision in a hospital setting after working hours.
>
> weekend hospital—a hospital setting providing a treatment program over the weekend. The patient resumes his usual work and activities outside the hospital during the week.

Occupational Therapy.—An adjunctive therapy that utilizes purposeful activities as a means of altering the course of illness.

Open Hospital or Open Ward.—Literally, a mental hospital, or section thereof, that has no locked doors or other forms of physical restraint.

Organic Psychosis.—A psychotic disorder caused by or associated with impairment of brain tissue function.

Weekend Hospital.—See Partial Hospitalization.

Preventive Psychiatry.—In traditional medical usage, the prevention or prophylaxis of a disorder. The modern trend, particularly in community psychiatry, is to broaden the meaning of prevention to

encompass also the amelioration, control, and limitation of disease. Prevention is often categorized as follows:

primary prevention—measures to prevent a mental disorder (e.g., preventing general paralysis with adequate doses of penicillin in treating syphilis).

secondary prevention—measures to limit a disease process (e.g., through early case finding and treatment).

tertiary prevention—measures to reduce impairment or disability following a disorder (e.g., through rehabilitation programs).

Speech Therapy.—Treatment designed to remedy a speech disorder.

Inhalation Therapy.—A treatment in which a chemical substance in gaseous form is inhaled.

Social Psychiatry.—The field of psychiatry concerned with the cultural, ecologic and sociologic factors that engender, precipitate, intensify, prolong, or otherwise complicate maladaptive patterns of behavior and their treatment; sometimes used synonymously with community psychiatry, although some limit the latter term to practical or clinical applications of social psychiatry. Important in social psychiatry is the ecological approach to maladaptive behavior, which is viewed not only as a deviation of an individual but also as a reflection of deviation in the social systems in which he lives.

Community Psychiatry.—That branch of psychiatry concerned with the provision and delivery of a coordinated program of mental health care to a specified population (usually all residents of a designated geographical area termed the catchment area). Implicit in the concept of community psychiatry is acceptance of continuing responsibility for all the mental health needs of the community—diagnosis, treatment, rehabilitation (tertiary prevention) and aftercare, and, equally promoting mental health and preventing psychosocial disorder (primary prevention). The organizational nucleus for such services is typically the community mental health center. The body of knowledge and theory on which the methods and techniques of community psychiatry are based is often called social psychiatry.

Stroke.—Apoplexy; cerebrovascular accident (CVA); gross cerebral hemorrhage or softening of the brain following hemorrhage, thrombosis, or embolism of the cerebral arteries. Symptoms may include coma, paralysis (particularly on one side of the body), convulsions, aphasia, and other neurologic symptoms determined by the location of the lesion.

Supportive Psychotherapy.—A technique of psychotherapy that aims to reinforce a patient's defense and to help him suppress disturbing psychological material. Supportive psychotherapy utilizes such measures as inspiration, reassurance, suggestion, persuasion, counselling, and re-education. It avoids probing the patient's emotional conflicts in depth.

Syndrome.—A configuration of symptoms that occur together and that constitute a recognizable condition.

Therapeutic Community.—A term of British origin, now widely used, for a specially structured mental hospital milieu that encourages patients to function within the range of social norms. Special educational techniques are used to overcome the patients' dependency needs, to encourage them to assume personal responsibility, and to speed their social rehabilitation.

Appendix 4

GEROPSYCHIATRY IN THE GENERAL HOSPITAL*

(By Alvin I. Goldfarb, M.D.[1])

Today the Mount Sinai Department of Psychiatry serves as a demonstration of the potential of general hospitals for inpatient diagnosis and treatment of mental disorders in old persons. Until about ten years ago voluntary nonprofit general hospitals played only a small role in the delivery of psychiatric care. (At Mount Sinai, many aged persons received psychotherapy during the course of medical care, including surgical or neurological treatment, by the liaison psychiatrist.) In the past decade, however, public "screening" hospitals (in which aged persons were observed prior to "certification," where depressed elderly patients could be treated by drugs or electroshock, and where even those with organic mental syndrome could be helped by modern expanding medical therapeutic efforts) have probably shortened the course of numerous disorders, have dispensed with the need for the transfer of many old persons to state hospitals, and undoubtedly have saved the lives of some others. Simultaneously, as increased facilities for psychiatric care became available in a few voluntary hospitals, more psychiatric beds have become available for old persons. A fourfold expansion of inpatient psychiatric beds in 1963 at The Mount Sinai Hospital made possible additional services for the aged. At that time a section of geropsychiatry was officially designated. This made possible the attraction and admission of many chronologically old persons.

Individuals 65 years of age and over comprised about six percent of the total psychiatric admissions in the years 1962 through 1965, and rose sharply to about ten percent in the period 1966 through 1969.[2] Included in this group were persons with (a) disorders of affect or thought content arising or emerging for the first time to a significant degree in old age, (b) recurrent mental illnesses, and (c) organic mental syndromes of various types and severity such as commonly occur with aging. The majority of these persons entered for definitive meliorative treatment; a smaller number arrived for clarification of diagnosis and stabilization of behavior in anticipation of the need for long-term protective care elsewhere. By admitting these patients, the hospital offered a new and useful service to the community, and simultaneously provided opportunities for staff training and for gaining information about the identification and treatment of psychiatric problems in old age.

---

* Reprinted from THE MOUNT SINAI JOURNAL OF MEDICINE Vol. XXXVIII, No. 1, January–February, 1971.

[1] For an article by Dr. Goldfarb on the need for a multi-system approach in providing mental health care, see Part III, p. 131, of this report.

[2] The assistance of Rafael Levi, M.D., in the collection of statistics is gratefully acknowledged. I am also indebted to Miss Laurel Sprung and Dr. Barbara Berkman for their "Study of Elderly Psychiatric Patients Admitted to The Mount Sinai Hospital in 1967". Unpublished, 1969.

The increase of over 50 percent in old persons cared for beginning in 1969 was undoubtedly related to their new Medicare-based financial eligibility for psychiatric services in a general hospital. Eligibility for general hospital care, however, does not guarantee that it will be accepted or be available. This is demonstrated by the fact that while the ten percent proportion of patient population is representative of the proportion of old persons in the general population, it is not representative of the large proportion of mentally ill old persons within the chronologically old group, which greatly exceeds the incidence and prevalence of mental disorder in younger age groups. Nevertheless, those old people who are now admitted to the general hospital receive more complete and satisfactory health care services than was generally available in the past or appears to be available elsewhere at present.

In the past, prior to Medicare, 93 percent of first admissions in old age to New York State psychiatric hospitals had organic mental syndrome, often severe, usually with clearly definable associated disorder of mood or thinking, The predominant number of the remaining seven percent suffered from disorders of affect or thought. By contrast, 40 to 60 percent of the first admissions in old age to private psychiatric hospitals, of which few now remain, were of persons with disorders of affect or thought content; those with organic mental syndrome made up the greatest part of the remainder. This accounted for large differences in death rate, recovery rate, and the proportion of persons returning to their homes after hospitalization; furthermore it led to a considerable difference in the experience of physicians who worked or were trained in these different institutions. At the same time many persons with mental impairment, often with associated disorders of mood or content, were admitted to old age homes or nursing homes.[3] Consequently, the patient population of old age and nursing homes included large numbers of individuals who, from the psychiatric point of view, were indistinguishable from persons admitted to State Hospitals. The best of these homes, for example, the Jewish Home and Hospital of New York, have contributed much valuable information about the diagnosis, care and treatment of mentally impaired old persons.

The differences in the distribution of patients in the populations of different types of institutions reflected different patterns in the search for, and in the use made of doctors, hospitals, and treatment programs by rich as compared to poor persons. Few rich persons with "senile" disorders reached state hospitals, no poor persons with affective disorders reached private sanitoriums, and a relatively small proportion of the poor with "functional" disorders chose to use state hospitals. With family aid large numbers of rich and middle income persons with mental impairment (often associated with physical disability or with functional disorders meshed with physical impairments) "chose" to live in nursing homes or found old age homes which would accept

---

[3] "Old age homes" are voluntary, non-profit, nonsectarian facilities usually endowed, supported, and maintained under sectarian auspices—e.g., the Mary Manning Walsh Home, Peabody Home, The Jewish Home and Hospital, the Hebrew Home for the Aged. They are selective in their acceptance of applicants, have long waiting periods which tend to influence the characteristics of admitted residents, and range in type from small and ill equipped to large quasi-hospital facilities. "Nursing homes," up to the present period, have been private proprietary, poorly staffed institutions which, although relatively nonselective in their admission policies, tend to dismiss problem patients later on. Since the creation of Medicare "extended care facility" and "intermediate care facility" standards have pressed proprietary nursing homes toward quasi-hospital functions which chiefly depend upon the patients' physicians for care and direction. Even more recently many proprietary homes have been moving away from accepting Medicare-financed patients of any kind and toward admitting persons whose private income, or Medicare status guarantees payment.

them. Large numbers of mentally ill poor persons, with the help of Old Age Assistance gravitated to nursing homes or to state hospitals. The State Department of Mental Hygiene is now trying to decrease its population of aged persons by "decree" which recommends avoidance of the admission of persons likely to need chronic or lifetime care and encourages the use of "community" nursing homes for its old, "institutionally adjusted" patients. These moves place state hospitals in competition with general hospital psychiatric services for the care of the remediably psychiatrically ill and impose upon the latter the burden of acute care of old persons whose basic disorders require long-term care.

A comparison of the characteristics of chronologically old patients admitted to the Mount Sinai Hospital psychiatric division in the periods before and after Medicare became effective sheds light on how or why patients tend to be sorted out for care. Before Medicare old patients fell into various socioeconomic and medical categories whose treatment appeared to differ accordingly. There were many rich persons with organic mental syndrome; their duration of stay was usually less than thirty days and seemed to be related to their hospital insurance coverage. There were relatively few rich persons with affective disorder, and again, their stay appeared to be related to insurance coverage; it lasted from 21 to 30 days and the treatment was most frequently by electroshock. Poor persons were not uncommon on the service; they were predominantly patients with affective disorder; few had organic mental syndrome. Their stay was longer—from two to three months—and this appeared to be related to the 90-day Community Mental Health Board financial limit for those eligible. The treatment of depression in this socioeconomic group appeared to be by way of drugs and conversation first, and only later, when this did not seem certain to promise recovery within the three month period, was there a turn to electroshock treatment. Also, all patients were not equally exposed to activities or to casework; the rich often received less active "team" treatment because more was left to the private physician who did not always provide it himself or ask for it.

These observations suggest that the psychiatric illness itself is not the sole determinant for hospital admission nor for the choice of treatment. Some additional elements of the sorting process are clear. Then, as now, hospital admission and medical care had social determinants. Community Mental Health Board-supported persons came as service cases who first were screened by residents. Their admission usually required, except for emergencies, a wait of several weeks from the time of application. Residents were more likely to accept the younger affectively disturbed, "more interesting" and "more hopeful" cases, and individuals who seemed more amenable to psychotherapy. Typically, aged persons with actual or presumed organic mental syndrome were likely to be considered beyond help, and often indeed appeared to be so acutely ill, and so disturbing, as well as disturbed, that they would exceed our capacity to care for them in an open ward setting without special nurses, which unfortunately they could not afford. The rich, conversely, were admitted without screening, on direct referral to semi-private status by their private physicians and usually had the ability to pay for special nurses when required. These observations suggest that money could often gain care which medical requirements alone could rarely command.

The advent of Medicare in July 1966 made for changes in the patient population with a slight but not complete shift toward that group characterized as "the rich." Medicare pays for anyone over 65 who needs inpatient psychiatric care for periods of up to 90 days, separated by "well" periods of 60 days spent out of an institution. However, it does not pay for special nursing. Consequently the admission of aged patients with organic mental syndrome who are ambulatory, active, and disturbed, or who are physically dependent and in need of much nursing care, continues to pose many problems to a psychiatric service with an open hospital orientation. The role of the general hospital in answering the needs of aged persons is not yet clear. At present it is in a transitional state in the development of psychiatric services. What it offers will eventually determine whom it serves. Possibly at some time in the future, services may be tailored to community needs as assayed by population surveys.

Despite the seeming limitations occasioned by financing, the small number of beds available, the biases of families and physicians, and the selection of patients as determined by hospital staff, or as dictated by its facilities and staffing patterns, a highly variegated group of patients has been helped. The wide variety has also been of instructional value to personnel on many levels.

From 1966 through 1969 (Medicare became effective in July, 1966) 418 of the 4,110 patients admitted to the Psychiatric Division of The Mount Sinai Hospital were over 65 years of age, 70 percent as private cases, 30 percent as service patients. In general the private patients were physically more ill and impaired, were older, their stay in the hospital was shorter, and a larger proportion of them had organic mental syndrome. While the ratio of females to males for the total group was roughly two to one, the female to male ratio was slightly higher among private patients. The latter, moreover, were more likely to have a living mate. For the total group, females were more likely to have suffered loss of a mate than males, which for some persons is a factor contributing both to the emergence of depression and to the absence of those protections that might avert the need for institutional care. Service cases, who stayed in the hospital longest, were most likely to require casework. Similarly, the younger, unmarried, and usually female patients were more likely to have had casework aid. In sum, it appears that the richer in money, in family, or in both, the more likely it was the psychiatric hospital admission took place later in life, was of shorter duration, and less frequently enlisted casework aid, despite the more frequent presence of brain syndrome.

As in other divisions of the department, service cases in the Geropsychiatric Division are cared for by residents under the supervision of preceptors, staff psychiatrists, and attending psychiatrists. Private geriatric cases, on the other hand, have their individual physicians. Nevertheless, it has been the private patients who have provided much, if not most, of the teaching material for residents. This has been determined by two factors. First, the tendency of residents in screening to select younger patients reduces the number of beds available for aged service cases. Second, the eligibility of old persons for Medicare-financed hospital care and of a personal physician generally leads to their desire for and selection of the private-patient status. This has led to the development of team approaches to private patients in

which residents and caseworkers have been encouraged to take as much initiative and responsibility as the "nonservice" status of such patients will permit. Internists, surgeons, neurologists, and other specialists have all joined in demonstrating how comprehensive care can be brought to patients admitted to a service-case-oriented unit by teams. This can serve equally well as a model for physicians interested in independent private practice, group practice or the delivery of comprehensive care services by a public agency.[4]

Aside from the care they received many of our older patients served as "experiments in nature," contributing significantly to the clinical experience and knowledge of our staff. A particularly vexing problem especially among old persons is the diagnosis of organic mental syndrome. Some years ago a Mental Status Questionnaire (MSQ) was devised by Kahn, Goldfarb, and Pollack, which together with M. Bender's Double Simultaneous Stimulation (Face-Hand) Test have proven valid and reliable aids in making the diagnosis of brain syndrome. An example of the importance of these diagnostic tools is given. Mrs. S., aged 80, was admitted early in 1967 "confused, agitated, suspicious and delusional." The MSQ and face-hand tests, however, suggested that her disorientation and confusion were more apparent than real. Treatment with a phenothiazine and lithium carbonate yielded calming, clearing of the delusional ideas, and clarity of thought. Mrs. S. might be called a case of "pseudodementia;" therapy proved she had a reversible "functional" disorder. Our tests, initially, quickly differentiated her from the group of the seemingly hopelessly brain-damaged persons and helped us avoid an initial diagnostic impression of dementia.

Just as depression can be mistaken for brain syndrome so may excited hypomanic patients be mistakenly diagnosed as "confused" and "demented," as I have reported elsewhere.

A converse problem was presented by Mrs. R., a 70-year-old women, who was admitted because of delusions, which Capgras and Reboul-Lachaux have characterized as the "illusion of doubles". She insisted that her husband was an imposter, apparently because he was no longer the strong and able man she recalled and felt she now needed; she talked in a scattered, short-circuiting fashion, and appeared to be reporting bizarre hallucinations. However tempting it was to make a diagnosis of schizophrenia alone, reliance on the mental status questionnaire score and upon her responses to the face-hand test led to a recognization of her condition as organic. This was confirmed by her response to treatment. A relatively long period of hospitalization and judicious use of medication did not help. Her future course over the years has been one of increasing degree of brain syndrome. Mrs. R. is an example of true "dementia," who might easily have been mistaken for a person with functional disorder. Her organic mental syndrome with elaborations of fear and anger might have been mistaken for a purely schizophrenic disorder recurring in or continuing into old age.

The "functional" disorders in old age may be thought of as being no different in diagnosis or response to treatment than in younger persons, although they frequently pose puzzling and difficult problems.

---

[4] I am especially grateful to Dr. Isadore Gerber and Dr. Robert Jaffe for their assistance in implementing much of this team approach in the Geropsychiatric Division.

Mention has been made that, as with younger patients, time and financial considerations may press the staff toward the use of electroshock. In contrast, individual characteristics such as verbal facility, appearance, manner of self-presentation ("warmth," "charm") and a similarity of status and cultural background between patient and doctor may lead to the choice of conversational techniques of treatment, while age differences may augment the likelihood that physical methods of treatment be chosen. Beyond these spurious indications for choice of treatment lie some problems which the geriatric service is attempting to clarify and study.

Electroshock treatment (ECT) is undoubtedly one of the most dramatically effective methods of decreasing the suffering in, and shortening the course of, depression in old people. Furthermore, contrary to some opinions, it does work well even when schizophrenic or overt paranoid features are present. This, however, does not necessarily make it the treatment of first choice. It may be a wise choice in special circumstances, among which are financial considerations or lack of hospital facilities.

Few old people suffering from a recurrence of a depression seek electroshock therapy, although it may have been used in earlier depressions. Often, when such illness recurs, they tend to withdraw, hide their disorder, avoid the physician, and refuse hospitalization if it is recommended. This is in contrast to those old persons whose past depressions were treated by medication, conversation, "environmental manipulation" (such as change of milieu), and the expectant use of hospital care. They may themselves ask for and seek out their "old friend," the doctor, for help in easing or eliminating their distress. This difference does not appear to be explained on the basis of how, for psychiatric reasons, patients are selected for one or the other type of treatment, but rather how a particular treatment affects the patient's view of himself, his personal protectors, and his physician.

In the case of ECT, fear, distaste, and a conviction that the patient will be dealt with over his objections play an important part, for this treatment involves "being handled" in a quasi-surgical fashion, with preoperative preparation, recovery rooms, and a post-treatment confusional state. For many it connotes a condition in which personal control is relinquished, and where physical as well as mental dependence upon others is made overt and total. Thus, management of depressive disorders in the old by way of conversation, supportive, motivating, stimulating milieus and medication appears to be the treatment of first choice. Such an approach permits the evolution of an understanding of the disturbance by the patient and his family together with the development of relationships to medical personnel, which in turn encourage and favor the search for, and good use of, treatment, should the condition recur. Avoided is the need to "pick up the patient repeatedly by the scruff of the neck" and to confine him, often against his will, to a place where "he can be made better." Gained is a personal understanding of a troublesome but meliorable disorder for which there is a treatment that does not do damage to self-confidence and pride. Incidentally, it should be added that when electroshock is used, it should be as much as possible in the context of a personal relationship with a physician. Conversation before and during the course of treatment may aid the patient understand his need for help, and minimize the impression of impersonality.

Lithium carbonate was initially introduced into the hospital in the geriatric patient population. Its use in this age group has provided many clues to the clinical monitoring of lithium efficacy and toxicity. As a safeguard, clinical observation is preferable to dependence upon monitoring by way of blood levels. Because of the rapidity with which toxicity can become manifest in the aged, all personnel have become alerted to lithium-induced lethargy, ataxia, tremulousness, "blackouts," gastrointestinal and cardiovascular symptoms. The woman of 80 years mentioned above provided an early demonstration of the value and safety of lithium in old persons. A review of her life history revealed her disorder to be one of a series of previously unrecognized depressive episodes. Now, after four years on lithium, she is managing well. She has minimal mood swings and no evidence of a significant degree of brain syndrome.

Problems of treatment are common in patients with organic mental syndrome. "Acute" reversible brain syndrome is treated by paying meticulous attention to the medical condition and by the elimination of pain, causes for anxiety or physiologic tension. It is now clear that we can change for the better behavior, mood, and even disorders of thought which occur as complications of chronic brain syndrome. But because the intellectual deficit is a reflection of diffuse brain damage, there is nothing we can do for the basic disorientation, memory loss, and other cognitive defects which characterize the disorder. The geriatric service has tested a number of treatments reported to have value. However, anticoagulants have not been systematically used. This general type of trcatment has not seemed to be of value in patients with brain syndrome in whom such drugs (e.g., coumadin) have been prescribed basically because of cardiac or other vascular thrombotic disease. Cerebral stimulants and vasodilators have been of no clearly demonstrable value. Recently, hyperbaric oxygen treatment was reported to show promise. Investigation by the geropyschiatric service of the value of this treatment in 16 cases did not confirm its usefulness. Familiar but neglected drugs like aspirin, the antihistamines and the amphetamines have proven to be of value as sedatives or stimulants. Old standbys like the barbiturates—when kidney and liver function do not contraindicate them—are demonstrably useful. Caffeine citrate may act paradoxically as a sedative in persons with brain damage. The use of high doses of vitamins C, B_1, and B_2 appears to warrant further study. Much experience has been gained in the use of phenothiazines and related substances, as well as with the tri-cyclic compounds. Some popular old-timers which are frequently advocated as both safe and helpful in the aged, like chloral hydrate, have been retried and found wanting.

In dealing with the aged in the general hospital several matters have become very clear. First, is the importance of meticulous medical attention and management. There are interesting relationships between cryptogenic disease and mental conditions such as depression and paranoid states in the aged. This is true for old persons with or without signs of brain damage. The importance of psychic elaborations as clues to physical disease as well as to personal and social problems remains continuously fascinating. The complaint of one man, for example, about "burglars in the cellar" was undoubtedly related to his fears about the recurrence of a rectal carcinoma. Obsessive concern in another man about the "plumbing downstairs at home" was clearly

a reflection of a disturbance in his genitourinary function. The patient with brain syndrome may point to specific problems by way of symbolic elaboration or he may use concrete current concerns to symbolize his more abstract complaints. Multiple physical complaints can often be understood as one aspect of a depressive reaction which usually occurs early and, with recovery, leaves late. On the other hand, the old patient with agitation, aggressivity, and disturbing behavior who may have no physical complaints on examination may show fecal impaction or distension of the urinary bladder related to spasm or to an obstructive lesion. Repeated careful medical examination must be a part of psychiatric care. The importance of physical pain, infection, uremia, anemia, and electrolyte imbalance is well known.

Second, it has become clear that a medical team is necessary to create optimal conditions for psychiatric improvement of old persons. The patient, his family, and others are reassured, supported, and sustained by the knowledge that psychiatrists, internists, nurses, and aides are actively concerned and are working together to supply supervision and care. All are relieved by the realization that if a more precise diagnosis might be disclosed by a special study, e.g., angiography, pneumoencephalography, brain scan, and lumbar tap, it will be performed.

Third, it has become apparent that older persons can be helped most in an atmosphere which recognizes and pays attention to the fear and anger generated by their losses of mastery, which responds to their elaborately disguised search for aid in protective ways, and which encourages utilization of their remaining assets. A schema helpful to all levels of personnel engaged in this approach has been refined by observations made on the service.

From the foregoing it is evident that the Psychiatric Department at The Mount Sinai Hospital has pioneered in the field of geropsychiatry. What further developments may be pursued in the future?

First of all, it would be logical to expand services so that they are adequate to the large population at risk in the geographic and ethnic catchment areas of the hospital. Our hospital, after all, serves both a local population and a more widespread group of Jewish persons. The probable number of beds required to provide adequate services to the aged can be calculated now on the basis of the known incidence of disorders in the general population. The number of beds available should vary with time as variable needs are discovered by periodic surveys of the two catchment areas served.

At the same time it may be helpful to have a separate, small geriatric section located geographically within the present psychiatric area. It should be specially staffed by teams consisting of psychiatrists, internists, neurologists, psychiatric residents, a charge nurse, assistant nurses, aides and clerks. From this focal point the staff could share responsibility for other old patients located in the psychiatric department and could also respond to hospital-wide requests for consultations. This unit should overlap with—i.e., supervise and help staff—an outpatient department for chronologically old persons, where its duties might be shared by a large number of attending and resident psychiatrists. There is need for a special team whose primary interest is in the aged, a team capable of "shifting of gears," i.e., making a change in attitude when turning from the young to the old.

Affiliation, through overlapping staff and interchange of patients, with an autonomous "old age home" equipped with a large well-staffed infirmary is another hope. In addition to providing necessary beds for long-term patients such a home could offer special opportunities for staff training and research. It could also provide short-term stay facilities for the special needs of patients whose families from time to time may need a rest or vacation from the task of caring for the old person. A nursing home area for long-term care which is an integral part of the hospital may be developed at some time. To make this a suitable "community" and an area which provides truly comprehensive care, this should either be under the supervision of the department of psychiatry or have a large psychiatric staff complement.

A home care service organization would be a welcome addition to the gero-psychiatric service. It could provide premilinary and perhaps prophylactic services for those who await admission, and it could provide after-care services for some who would otherwise need protective care in another institution but who for many reasons can be and would prefer to be at home.

Considerable effort may be required to aid patients and families in finding residential facilities in which the patient is comfortable, about which the family is pleased and which does not excessively burden the community.

Expansion of psychiatric efforts to include the family of the old person has already occurred. But such services need great strengthening. Psychiatrists need to have such efforts recognized as an important public health service, and it should become acknowledged as an essential aspect of psychiatric treatment. Such work requires that time, space, and remuneration be available. In the planning of services there is often a forgetting of how much telephone time, reporting time, time for reassurance, support, and direction are desperately needed. Very often a most useful aspect of the treatment of an old person is the benefits rendered to his family. This is especially true for the dying patient. Psychiatric interest in the dying patient is already great; too little interest has been displayed in his family. Aged patients are frequently slowly dying persons whose problems have wide family ramifications.