AGING AND MENTAL HEALTH: OVERCOMING BARRIERS TO SERVICE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-SIXTH CONGRESS

SECOND SESSION

PART 2—WASHINGTON, D.C.

MAY 22, 1980

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
67-899 O WASHINGTON : 1980

SPECIAL COMMITTEE ON AGING

LAWTON CHILES, Florida, *Chairman*

FRANK CHURCH, Idaho
JOHN GLENN, Ohio
JOHN MELCHER, Montana
DAVID PRYOR, Arkansas
BILL BRADLEY, New Jersey
QUENTIN N. BURDICK, North Dakota

PETE V. DOMENICI, New Mexico
CHARLES H. PERCY, Illinois
JOHN HEINZ, Pennsylvania
NANCY LANDON KASSEBAUM, Kansas
WILLIAM S. COHEN, Maine

E. BENTLEY LIPSCOMB, *Staff Director*
JOHN A. EDIE, *Chief Counsel*
DAVID A. RUST, *Minority Staff Director*

CONTENTS

	Page
Opening statement by Senator David Pryor, presiding	57
Statement by Senator John Melcher	59
Statement by Senator John Heinz	59
Statement by Senator Lawton Chiles, chairman	64
Statement by Senator Charles H. Percy	110

CHRONOLOGICAL LIST OF WITNESSES

Flemming, Arthur S., Ph. D., Washington, D.C., Chairman, U.S. Commission on Civil Rights	65
Klerman, Gerald L., M.D., Rockville, Md., Administrator, Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, Department of Health and Human Services; accompanied by Dr. Gene D. Cohen, Chief, Center for Studies of the Mental Health of the Aging, National Institute of Mental Health, and Steven S. Sharfstein, Director, Division of Mental Health Service Programs, National Institute of Mental Health	67
Benedict, Robert C., Washington, D.C., Commissioner, Administration on Aging, Department of Health and Human Services	87
Ewalt, Jack R., M.D., Washington, D.C., Director, Department of Medicine and Surgery, Veterans' Administration	93
Hutton, William R., Washington, D.C., executive director, National Council of Senior Citizens	96
Kerschner, Paul A., Ph. D., Washington, D.C., associate director of legislation, research and developmental services, National Retired Teachers Association/American Association of Retired Persons	100
Perkins, Clarence W., Washington, D.C., member, Public Policy Committee, National Council of Community Mental Health Centers	104
Sandler, David, Washington, D.C., director of Government relations, National Council of Community Mental Health Centers	105
Noble, James W., Tallahassee, Fla., gerontology program consultant, mental health program office, State of Florida; chairperson, representatives of State mental health programs for the aged, National Association of State Mental Health Program Directors	108
Brandt, Sandford F., Norris, Tenn., Government affairs committee, National Mental Health Association	112
Weinberg, Jack, M.D., Chicago, Ill., professor of psychiatry, Rush Medical Center; administrator, Illinois Mental Health Institutes	116

APPENDIX

Material related to hearing:

Item 1. Medicare mental health demonstration site selection criteria, submitted by Dr. Gerald L. Klerman	143
Item 2. Statement of the National Retired Teachers Association and the American Association of Retired Persons, submitted by Paul A. Kerschner	146
Item 3. Newspaper article, "Geriatric Psychiatry Is Much Enfeebled," from the New York Times, January 27, 1980, submitted by Dr. Jack Weinberg	156
Item 4. "Environment, Its Language and the Aging," article from the Journal of the American Geriatrics Society, September 1970, by Dr. Jack Weinberg	158
Item 5. "The Chronic Patient: The Stranger In Our Midst," article from Hospital and Community Psychiatry, January 1978, submitted by Dr. Jack Weinberg	161
Item 6. Letter and enclosure from Elma L. Griesel, executive director, National Citizens' Coalition for Nursing Home Reform, to Senator David Pryor, dated May 22, 1980	165
Item 7. News release from the Feedback Foundation, Inc., Santa Ana, Calif., dated May 22, 1980	166

AGING AND MENTAL HEALTH: OVERCOMING BARRIERS TO SERVICE

THURSDAY, MAY 22, 1980

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 9:10 a.m., in room 1202, Dirksen Senate Office Building, Hon. David Pryor, presiding.

Present: Senators Pryor, Chiles, Melcher, Burdick, Percy, and Heinz.

Also present: E. Bentley Lipscomb, staff director; David A. Rust, minority staff director; Carnie C. Hayes, Helena G. Sims, and Neal E. Cutler, professional staff members; Eileen M. Winkelman, minority professional staff member; Theresa M. Forster, assistant chief clerk; and Dianne C. Pearson, clerical assistant.

OPENING STATEMENT BY SENATOR DAVID PRYOR, PRESIDING

Senator PRYOR. The hearing will come to order.

Because of the excessive drilling on the new Senate Office Building next door, which I voted against, by the way, we are all going to have to speak very loudly this morning. I hope I won't have to keep reminding you of this, but I am sure that if you start getting quieter I will have to remind you once again to pick up the tone of your voice.

We are very excited about this hearing this morning. We hope this will be informal and not stifled because of lack of ability or motivation, I should say, to communicate fully and openly with each other. We think this is a very crucial subject. This is the second in a series of hearings for the Special Committee on Aging entitled "Aging and Mental Health: Overcoming Barriers to Service." We have some very knowledgeable and interesting witnesses this morning before the committee, and we are going to get underway just as soon as we can. We will also have statements by Senator Melcher and Senator Heinz, and we will proceed with those statements in a moment.

Before we get to the other statements, I would like to say that when I had the privilege of becoming a member of the Aging Committee and began looking into some of the issues and problems facing older Americans, I came across some very, very alarming statistics that were shocking. As a matter of fact, these statistics had to do with the mental well-being of the elderly in our country. I would like to share just a few of these facts with you.

Twenty-five percent of all reported suicides are committed by persons over age 60.

Severe senility affects over 1 million older Americans and life is reduced by two-thirds after the onset of this condition.

Two million of our Nation's elderly suffer from a mild to moderate form of organic brain syndrome.

Psychosis, the most serious type of mental disorder, increases significantly in the over-65 age group and is twice as common in persons over 75 as in the 25–34 age group.

Depression is the most common mental problem and it more frequently strikes the elderly.

Fifteen to twenty-five percent of the elderly have significant symptoms of mental illness.

Thirty percent of the beds in public mental hospitals are occupied by the elderly.

What is so disturbing about these statistics is that older Americans do respond well to mental health treatment when properly diagnosed and when professional help is available. For example, 10–25 percent of the cases of organic brain syndrome, or senility, are treatable, and there are about 100 reversible conditions in which the symptoms are similar to senility. We have learned that mental problems of older persons may actually have a physical origin or be related to overmedication of prescription drugs.

However, additional studies and reports over the last 10 or 20 years have shown the elderly to be grossly underserved by the existing mental health system.

Less than 4 percent of the direct services by community mental health centers are for older Americans.

Less than 6 percent of the consultation and education programs by community mental health centers go to facilities and agencies which primarily serve the elderly.

The medicare expenditures for mental health services for the elderly and the disabled are less than 2 percent of the total.

Only about 4 percent of the resources of the National Institute of Mental Health are directed to research, training, and services for the elderly.

Last month, I chaired a hearing on this subject in Arkansas. We heard testimony from community mental health centers, area agencies on aging, the Veterans' Administration, State directors on aging and mental health, and private practitioners. These administrators and professionals had some very encouraging results to report on improved delivery. For example, our State of Arkansas is small and it is rural. In our State, we have the only community mental health center which is also a rural health clinic. This type of arrangement makes diagnosis and finding the right combination of physical and mental health care a great deal easier. We also have in our State coordination, we think, that is getting even better, among community mental health centers and area agencies on aging to permit delivery of services at sites for older people.

The purpose of our hearing today is to draw together the administrators of programs and representatives of organizations at the national level. We want to see where we are now in coordination of services and sharing of knowledge and to determine how older Americans might be better served by more cooperation among agencies and organizations that must effect these changes. The Senate is now going to

be considering legislation later this year which has incorporated the findings of the President's Commission on Mental Health and other recommendations on more effective delivery of community services to the elderly.

Hopefully, we can improve our track record, but if we do, we must act now so that in the years to come we will read statistics which will show that there have been drops in the rates of suicide, serious mental illness, depression, senility, and institutionalization among older Americans.

Before I introduce our panel this morning, ladies and gentlemen, if I could, I would like to call on our friend from Montana, a very valued member of this committee, Senator John Melcher, and then I will call upon Senator Heinz.

STATEMENT BY SENATOR JOHN MELCHER

Senator MELCHER. Thank you, Senator Pryor.

I want to commend you and Senator Heinz for setting up this hearing. I think it is most timely and most helpful.

I have several concerns about mental health and the elderly. In the years ahead, how will we provide the opportunity for the elderly to remain in the mainstream of life? How can institutionalization be avoided? How can the elderly be treated promptly and, if necessary, receive additional care and treatment in their own communities?

Montana is a very small State in population but a large State in land area. It has been very conscious of the failures in treating mental health problems inside of an institution. We have had a program of deinstitutionalizing the people once in our State mental health institution in Warm Springs. We feel the results have been very fine. We are most encouraged by it. We are going to proceed along that path and try to improve on it and continue to use our community mental health centers as vehicles for treatment.

We have an operation in Lewistown, Mont., where the elderly who require constant care and have mental health problems are taken care of in an open campus-type institution; fortunately not the type of mental health institutions that we used to see 20 years ago—I hope we are well past that. My main concern in these hearings will be the methods and the procedures followed in treating mental health problems of the elderly and the value of community based treatment.

Thank you, Senator Pryor.

Senator PRYOR. Thank you, Senator Melcher.

Senator Heinz.

STATEMENT BY SENATOR JOHN HEINZ

Senator HEINZ. Mr. Chairman, thank you very much.

I am pleased that you scheduled these hearings and I am pleased to be a part of the efforts to chart a course for future action by Congress to ameliorate what has been an all too tragic history of misinformation, misconception, and misinterpretation about the needs of older Americans who have been or may someday be diagnosed as mentally ill. I appear here as one of the few members, I believe, of this committee to serve also on the Finance Committee which, as we all know, has jurisdiction over medicare and medicaid—programs which do now

to some extent, but have a much greater potential to, address the mental health needs of our elderly.

Senator Pryor, you have quite eloquently set forth the statistics portraying who the elderly are that we are talking about, as well as some of the kinds of problems with which we must deal. I would just like to reemphasize one of your points; that is, that according to the President's Commission on Mental Health, perhaps as many as 25 percent—it could be a few less, it could be even more—of those persons described as senile actually have diagnosable, treatable, reversible disorders. Unfortunately, that group is simply not being provided with appropriate services. This brings me to my second concern, the existing system of health care.

Mr. Chairman, in the past those elderly who have been diagnosed and then treated for mental illness have characteristically been treated in the State and county mental hospitals of this country. While constituting 10 percent of the total population in 1975, they represented 28 percent of the mental hospital population. While there have been great efforts to deinstitutionalize such individuals and to provide noninstitutional care for those not previously hospitalized, the current Federal health care system is not structured to meet such needs. Specifically, we know the following facts to be true:

First, the deinstitutionalized are most likely to be rehoused in nursing homes where there is a disincentive to receive active treatment for mental illness, because if for no other reason, of the medicare/medicaid law restrictions.

Second, the elderly represent a mere 4 percent of the population seen by the community mental health center program.

Third, medicare and medicaid stress treatment for acute disorders, whereas the elderly suffer from disorders marked by longevity and chronicity.

The net effect of the preceding, in human terms, is staggering. Upward of 3 million persons requiring services receive either no care or inappropriate care, and continue to suffer a host of nervous, mental, or emotional impairments that are treatable and reversible. Our fragmented, acute-care oriented Federal health care delivery system is inadvertently, and unintentionally, assuring that millions of older Americans do not receive the care needed to allow them to reenter the mainstream of society and become productive, active participants.

Of course the question is, what can we do about it? That, Mr. Chairman, is why you have brought us together today. That is why I am here; that is why our witnesses are here. I must say for my part, Mr. Chairman, I believe that it is time that our medicare program be revitalized to serve the purpose for which it was intended, and that is to meet the health care needs of the elderly and the disabled.

One approach that I believe is viable and have introduced in legislative form, would begin such revitalization for the mentally ill elderly population. I am specifically talking about legislation that calls for:

One: Elimination of the 190-day lifetime limit for inpatient psychiatric care.

Two: Replacement of the 50–50 copayment for mental health services with the same 80–20 copayment required for physical health care under medicare.

Three: Elimination of the $250 annual ceiling for outpatient mental health care and replacing that unfair and inadequate control with a strong utilization review requirement.

Four: Allowing community mental health centers to qualify for provider status whether or not they are operated under the aegis of a hospital.

Five: Providing coverage for partial hospitalization services for mental health care by qualified providers, including community mental health centers.

I believe that such measures are critical in order to encourage the provision of the much needed community based outpatient care in lieu of more costly and often inappropriate and unnecessary, inept institutionalization.

Mr. Chairman, I know there are many other proposals and I don't mean to cite mine to the exclusion of others. However, I have done work in this area and I do believe that whether we approach it in the way I have suggested or the way others have suggested, we must act decisively and with some considerable speed because the number of people that we are talking about is growing daily.

I just want to take this opportunity, Mr. Chairman, to compliment you once again for your interest in these matters, which I know go back well over a decade when you first came to serve in the House of Representatives. We are glad you are here.

Senator PRYOR. Thank you.

Thank you, Senator Melcher and Senator Heinz, for your fine statements.

This is a little personal thing I would like to tell about Senator Heinz. I will never forget when I left the House of Representatives in 1972. One day I looked up and Senator Heinz was standing in the doorway. He was then Congressman Heinz, and he said if he could, he would like to have all of the files that I had on the elderly and those things that I had done at that time. I remember that I gave most of that to you, John.

Senator HEINZ. I still have it.

Senator PRYOR. I now want it back.

I remember that you did such a wonderful job there as did Senator Melcher in those days over in the other body, as we call it.

At this point we will place in the record the statement of Senator Pete V. Domenici, the ranking minority member, who is unable to be with us today.

[The statement of Senator Domenici follows:]

STATEMENT OF SENATOR PETE V. DOMENICI

Mr. Chairman, I am pleased to have this opportunity to participate in today's hearing of the Senate Special Committee on Aging on "Aging and Mental Health: Overcoming Barriers to Service." I would like to commend you, Senator Pryor, for your leadership in aggressively seeking out answers to the critical question of why our mental health care delivery system has consistently failed to meet the mental health care needs of older Americans.

The statistics on this subject are truly alarming. It is shocking to me to note that 50 percent of the institutionalized elderly are in long-term care facilities because of a diagnosis of senility—a condition which we now know is frequently reversible with proper treatment. The fact that 30 percent of all beds in public mental hospitals are occupied by the elderly is another sad commentary on the failure of current mental health programs to meet the needs of the elderly.

Various federally mandated studies and national commissions have, time and again, recommended that an aggressive effort be made to bring the elderly into the mainstream of our mental health care delivery system. However, the statistics continue to indicate that the goal of providing increased mental health services to the elderly has not begun to be met in any meaningful way.

I understand that certain States have achieved an encouraging and commendable measure of success in their efforts to coordinate programs and improve the quantity and quality of mental health services offered to the elderly. The time has come to see how we might accomplish this same kind of coordination and improvement in service delivery at the national level. I look forward to hearing today's witnesses discuss how we can, on the national level, more effectively and efficiently focus in on, and begin to adequately meet, the mental health needs of our older Americans.

Senator PRYOR. Very quickly we are going to introduce our panel of witnesses. We have 12 or 13 people who are very knowledgeable in this field and who are going to be able hopefully to answer some of the questions that we have and at least address some of the problems that we face.

I am not going to read all of the biographical information on each of these outstanding citizens. I am going to ask them if they would quickly start with Dr. Flemming and ask Dr. Flemming if he would briefly tell a few things about himself. We will then move to our next witness. We will take both panels and then we will begin by informal statements by each of the witnesses.

Dr. Flemming, we will start with you. Just give a paragraph sketch on yourself.

Dr. FLEMMING. Mr. Chairman, I am here this morning in my capacity as Chairman of the U.S. Commission on Civil Rights. Personally, I have a very deep-seated interest in the subject matter not only from the point of view of the Commission on Civil Rights, but also from the experience that I had as a U.S. Commissioner on Aging.

Senator PRYOR. We are glad to have you here, Dr. Flemming.

Dr. KLERMAN. I am Dr. Gerald Klerman, Administrator of the Alcohol, Drug Abuse, and Mental Health Administration of the Public Health Service, which is a component of the new Department of Health and Human Services. I am accompanied by two of my colleagues from the National Institute of Mental Health, an institute of the agency.

Dr. SHARFSTEIN. My name is Dr. Steven S. Sharfstein. I am a psychiatrist. I am Director of the Mental Health Services Division in the NIMH. Our Division is responsible for the Federal accountability of the community mental health centers and community support program and we have been quite involved in the design of the pending Mental Health Systems Act.

Dr. COHEN. I am Gene Cohen. I am Chief of the Center for Studies of the Mental Health for the Aging at the National Institute of Mental Health. I am a psychiatrist. The focus of our center is on looking at programs for the elderly nationally in the areas of services, training, and research.

Mr. BENEDICT. I am Bob Benedict, Commissioner of the Administration on Aging. Care of the aged who have mental problems relates to the activities of the Administration on Aging and our interest in long-term care and chronic impairment.

Dr. EWALT. I am Jack Ewalt. I am a psychiatrist and Director of the Mental Health and Behavioral Sciences Services for the Veterans' Administration.

Senator PRYOR. By the way, I hear there are more psychiatrists in Washington than in any other part of the country.

Dr. EWALT. I think that is the most per thousand population.

Senator PRYOR. In fact, and Senator Melcher may back this up, I understand there is one building on Connecticut Avenue where there are more psychiatrists than there are in more than 10 Southern States. I don't know what that says.

Dr. EWALT. In some States it could be a small building, sir.

Mr. HUTTON. I am William Hutton, executive diretor of the National Council of Senior Citizens.

Apropos of your last remark, it is not surprising that there are so many psychiatrists. Perhaps you might consider that the proximity to the seat of Government might do that.

Senator PRYOR. That says a lot right there.

Dr. KERSCHNER. I am Paul Kerschner, associate director of legislation, research, and developmental services of the National Retired Teachers Association/American Association of Retired Persons. We are interested in the utilization of older people in the delivery of mental health services.

Mr. PERKINS. I am Clarence Perkins, member of the public policy committee, National Council of Community Mental Health Centers. Our business is to provide services in communities throughout the United States.

Mr. SANDLER. My name is David Sandler and I am director of Government relations of the National Council of Community Mental Health Centers. During the past year, we have been involved with the Mental Health Systems Act as well as trying to end the barriers in forms of discrimination in the medicare laws against the mentally ill.

Mr. NOBLE. My name is James Noble. I am the gerontology program consultant with the mental health program office, in the State of Florida, and also chairperson of the representatives of the State mental health programs for the aged, which is a division of the National Association of State Mental Health Program Directors.

Mr. BRANDT. I am Sanford Brandt from Norris, Tenn. I am a mental health volunteer and testifying on behalf of the National Mental Health Association and its 800 affiliates across the country. I have been active as a volunteer for about 25 years at local, State, and national levels. I think one of the proudest things I have ever done is be a cofounder of a CMHC.

Dr. WEINBERG. I am Jack Weinberg. I am a psychiatrist and professor of psychiatry at Rush Medical Center and administrator of the Illinois Mental Health Institutes. While I am here in a private capacity, I would like to mention that I am also chairman of the council on aging of the American Psychiatric Association, an association of 25,000 members, and I have also had the honor of serving as its president.

Senator PRYOR. One more individual who is in our audience but not on the panel today is an old and good friend—not old but a friend of many years I should say. John Martin is sitting in the audience. I would like the record to reflect that Commissioner Martin is with us today. We appreciate your attendance and your interest.

Also joining us at this time, and I would like to turn the microphone over to this very distinguished gentleman, is Senator Lawton Chiles from Florida. He certainly is no stranger to us; he is chairman of this

committee. Senator Chiles, we are very proud that you could come and join us today.

STATEMENT BY SENATOR LAWTON CHILES, CHAIRMAN

Senator CHILES. Thank you, Mr. Chairman.

I am delighted to have an opportunity to be here today. I want to compliment you for the leadership that you have shown in the area of mental health of the elderly. As we are examining how to try to deal with long-term care, there is certainly no way we can approach that subject without trying to deal with the mental health aspects both of our older citizens that are institutionalized and those that we are trying to provide some kind of outpatient care for.

I want to thank you very much for your work in this area, and also Senator Heinz, who has also shown great interest in this area.

I know we have a distinguished panel of witnesses. We are delighted to have Jim Noble up from Florida. He has worked long and hard in this area and I am delighted that he is sharing his experience with us here.

Senator PRYOR. Mr. Chairman, we are very honored that you could join us this morning at this hearing.

I would like to maintain a very informal format this morning. I am going to ask Dr. Flemming to be our first speaker. Dr. Flemming and the other individuals who will testify this morning have consented to attempt to hold their remarks to from 3 to 5 minutes. We are going to try to get them to confine their remarks to that time period so that all speakers can have an adequate amount of time and then we can have a number of questions to ask these people while we have them all under one roof. This is a very unique situation for us to have the opportunity of questioning all of you at this particular time, and we certainly want to avail ourselves of that very rare opportunity.

Finally, I would like to say that we want to stress the positive intent that we have at this hearing this morning. I know when we are in a situation where we are discussing discrimination and the failure of our system to serve a particular group like the elderly there is probably a tendency for all of us to think we are looking for someone to blame this whole situation on. Well, I am saying that that is not going to be very productive. I think we ought to be very honest and candid with each other, but I hope that we will also ask for the whys and hows—why it has been so hard to reach out for older people who need these services, how we can overcome these barriers, and how we can best serve their needs. We should keep that in mind, as well as the potential for groups and agencies to do something with limited resources that no one individual could have done alone. I think that we are going to get a lot out of this hearing in terms of a future commitment.

Now I am going to ask Dr. Flemming if he would proceed. After he finishes, I, or the members of the panel on this end, will have an opportunity to ask Dr. Flemming a question or two, and then we will move to our next witness. Before we get through, we will just have an interchange of not only around the table, but across the table throughout the morning.

STATEMENT OF ARTHUR S. FLEMMING, PH. D., WASHINGTON, D.C., CHAIRMAN, U.S. COMMISSION ON CIVIL RIGHTS

Dr. FLEMMING. First of all, may I express to you, Senator Chiles and Senator Heinz, our deep appreciation for the leadership that you are providing in this very important area. I am very happy to have the opportunity of being here as a representative of the U.S. Commission on Civil Rights. Virtually every authority that has looked into the matter acknowledges that older persons as a group have a relatively higher need for mental health services compared to other age groups.

As you know, in 1975, the Congress directed the U.S. Commission on Civil Rights to conduct the study of age discrimination in federally assisted programs. The community mental health centers program, authorized by the Community Mental Health Centers Act, was one program examined by the Commission. Based on the information we gathered through our field study and four public hearings, the Commission concluded that age discrimination exists in the community mental health centers program. Older persons have never represented any more than 4.1 percent of the program's participant population. Few centers that we covered conducted any outreach designed to build a bridge between the older population and the mental health services team, yet it was universally recognized that such services were necessary to reach older persons in need.

The lack of mental health personnel trained or experienced in treating older persons was a major barrier to services provision. Scarce resources was the principal reason assigned for the failure to serve older persons. Some administrators alleged that they believed it constituted sound public policy to concentrate scarce resources on the young and middle aged instead of meeting the needs of older persons. A specific statement to that effect, made at our San Francisco hearing, has continued to haunt me. It was as follows:

> This—the cost-benefit argument—is a rationalization * * * that is used by people not to offer services to older people; that because they are old they don't have very much more to live and since we have limited amounts of money, we are going to spend it on younger adults or on children. * * *

The Commission believes that such a policy is a clear manifestation of ageism and is in direct conflict with the Age Discrimination Act of 1975. The Commission also believes that existing law places on administrators an affirmative obligation to see to that older persons know about and are provided access to the resources, for example, of community mental health clinics to the same extent that persons who belong to other age groups are acquainted with and granted access to these resources. Lack of resources is not a valid reason for practicing discrimination against older persons in determining how to allocate whatever resources are available.

However, not only community mental health centers, but the entire field of mental health has generally failed to respond to the needs of older persons.

One: Misdiagnosis continues to be a serious problem.

Two: Many older persons have been the victims of inappropriate discharge from mental health facilities without appropriate followup care.

Three: Inappropriate placement in institutional care setting persists.

Four: Relatively little progress has been made to train mental health personnel to meet the needs of older persons.

We support the enactment of S. 1177 because it does have as one of its primary objectives the granting to older persons of access to mental health services that are supported by Federal dollars. We believe that, for example, the inclusion in the legislation of the "bill of rights" and "mental health advocacy" provisions will make it clear that the Nation is committed to translating rhetoric to action in this important area.

Senator PRYOR. Thank you, Dr. Flemming.

I was interested when the Commission originally looked at the community mental health program. Legislation has recently been passed, or had recently been passed, to require specialized services to the elderly, but these centers were given a period of 3 years to phase in these new services. In following up the delivery of mental health services to the elderly by the centers, I wonder if you have noted any improvement or are things the same or are they getting worse in the delivery of these specialized services?

Dr. FLEMMING. We have not, Mr. Chairman, had the opportunity of following up on the study that we made by direction of the Congress. Consequently, I am not in a position to provide any up-to-date statistics on that.

Senator PRYOR. Perhaps some of our other panelists during the morning might be able to provide some enlightenment in that area.

A related question, I think, that would be appropriate for Dr. Flemming relates to the role of the Congress in the elimination of age discrimination. I have always wondered if we should be more strict or if we should attempt to draft more narrow legislation in that particular area so we might better prevent age discrimination in these and other programs.

Dr. FLEMMING. Mr. Chairman, it seems to me that wherever legislation is before the Congress, such as the legislation that is now pending in the mental health field, it is important for the Congress to underline the congressional intent that older persons are to be served with the resources that may be made available through the legislation. Now it is true that the Congress has enacted the Age Discrimination Act of 1975, which applies across the board insofar as programs that are supported in whole or in part by the Federal Government are concerned. Nevertheless, I think it is important to include in legislation related to specific programs a prohibition against discrimination on the basis of age. In addition to that, I think it is very important for the Congress to make it clear that it is placing on the administrators of such programs an affirmative responsibility to conduct outreach programs. It is one thing to outlaw discrimination by legislation, but that is not going to be very meaningful unless it is accompanied by affirmative action programs in this area, just as is the case in all other areas where we are combating discrimination.

Senator PRYOR. Thank you, Dr. Flemming.

We have another valued member of our committee who has just joined us this morning, and he has a markup in a few moments, I understand, in another committee, so I am going to call on Senator Burdick if he would like to make a statement at this juncture.

Senator BURDICK. Thank you, Mr. Chairman.

I don't have a statement to make at this juncture. I have two questions to ask Dr. Weinberg when he is here. I am free until I get a telephone call.

Senator PRYOR. We will await your call.

We will move right along and try to ask as many of these questions as we can.

I think that we should at this time move to our next witness, Dr. Klerman. Dr. Klerman, you are free to make your statement and we might ask you some questions right after you speak or after we conclude with some other witnesses.

STATEMENT OF GERALD L. KLERMAN, M.D., ROCKVILLE, MD., ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY DR. GENE D. COHEN, CHIEF, CENTER FOR STUDIES OF THE MENTAL HEALTH OF THE AGING, NATIONAL INSTITUTE OF MENTAL HEALTH, AND STEVEN S. SHARFSTEIN, DIRECTOR, DIVISION OF MENTAL HEALTH SERVICE PROGRAMS, NATIONAL INSTITUTE OF MENTAL HEALTH

Dr. KLERMAN. Thank you, Mr. Chairman.

Let me add my appreciation for the leadership shown by you and other members of this Senate committee.

I am head of the Alcohol, Drug Abuse, and Mental Health Administration known as ADAMHA. We are one of the six agencies of the Public Health Service, which is in turn one of the major components of the recently named Department of Health and Human Services. There is a wide recognition within the Public Health Service and within the Department of the gap between services and needs of the elderly. Mrs. Harris, the Secretary, has convened a task force on long-term care which is now reviewing this issue, particularly as it applies to the elderly, not only for mental health, but for all health and human services. In addition, one of the recommendations of the President's Commission on Mental Health was that the Department should review its programs on the chronically mentally ill. Dr. Richmond, the Surgeon General, and I are cochairing a group within the Department on this matter to develop a national plan.

ADAMHA is comprised of three institutes—Mental Health, Drug Abuse, and Alcohol Abuse and Alcoholism. My two colleagues, Dr. Sharfstein and Dr. Cohen, are from the National Institute of Mental Health and they will say more about the specific programs of NIMH.

There is no doubt that the evidence that you have summarized is accurate, that there is a major gap between the prevalence of mental health problems among the elderly and the extent to which they use community facilities. The paradox is that the elderly are overrepresented in the institutions and underrepresented in community facilities such as community mental health centers, outpatient clinics, and private practitioners' offices. To a certain extent, this problem is a reflection of the success of the Public Health achievements. Dr. Richmond, the Surgeon General, has pointed out recently that there has been an increase in longevity in this country because of the decrease in

deaths due to cardiovascular disease and stroke. Therefore, more of our population is surviving into the elderly age group.

Furthermore, whereas 65 years of age was previously the period at which there was limited activity, the age of functional disability—as has been pointed out by Dr. Butler of the National Institute of Aging—is now past 75 years of age and people aged 65 to 75 can expect to be vigorous, active, and independent. Nevertheless, we still recognize that there are significant barriers to the provision of mental health services for the elderly and ADAMHA, the rest of the Public Health Service, and HHS is committed to acting in a concerned manner to reduce these barriers.

Let me identify a number of barriers. The most significant is probably the one that has to do with the current reimbursement program in both public insurance programs, such as medicare and medicaid, but also private programs which reinforce inappropriate placement in institutional care settings and act as disincentives to community treatment. There are currently demonstrations underway within the Department, jointly shared by the National Institute of Mental Health and the Health Care Financing Administration—HCFA—to explore the feasibility of community alternatives to institutionalization and for provider status for community mental health centers under medicare. We also have a commitment from HCFA to explore with greater vigor alternative financing and search for new incentives for community placement.

A second barrier is inadequate training in the needs of the elderly among professionals and other mental health workers. This, of course, has been pointed out by Dr. Flemming and leads sometimes to misdiagnosis and inappropriate treatment. In response to congressional interest, the National Institute of Mental Health has set up a special unit on the mental health needs of the elderly whose chief, Dr. Cohen, is here. He will describe some of our efforts to improve training. There is evidence that the field of geriatric psychiatry is in a very dynamic growth base with a large increase in numbers of individuals identifying themselves as specialists in this area. Further, there is a growing development of new expertise, enthusiasm, and optimism about the efficacy of treatment and diagnosis.

At the same time, it must be recognized that among many mental health professionals there still remain negative attitudes toward treating the elderly. Although this is changing, we still have a responsibility to proceed with greater vigor, and to follow the recommendations of the President's Commission. The Department has established a task force on public understanding and the reduction of stigma. One important component will be to deal with the misconceptions and stigma around the mental health needs of the elderly and the common misconceptions, not only among the public but among professionals as well, that problems of the elderly are not reversible and do not merit attention.

We also recognize that there is inadequate coordination among various health and human service agencies in planning for comprehensive needs, particularly among the deinstitutionalized and noninstitutionalized elderly. We should recognize that 95 percent of the elderly are not in institutions; they are in the community with their families or living alone in their own homes or apartments. We are involved

in an active set of exchanges, the Public Health Service and Mr. Benedict's agency, to improve coordination at the local level.

Ultimately, of course, we will need more programs at the community level. The evidence indicates that where programs exist and where they make outreach efforts and are accessible, the fears and stigma are rapidly reduced, and in those instances such as in Arkansas and elsewhere where demonstration projects have been undertaken, the elderly do respond to appropriate programs and do come forward to seek help, and the results are very encouraging.

Senator PRYOR. Pardon me, if I might. If you or any of the panelists this morning have longer statements than you care to read, we welcome you to place the entire statement in the record for our hearing.

Dr. KLERMAN. Very well.

Senator PRYOR. I would at this point like to ask you a question. I think Senator Chiles also has some questions and Senator Heinz.

Within the National Institute of Mental Health, why is it that only 4 percent of the total resources are used for research and training and services going for the elderly? This is a great concern that I have and other members of this committee have. Why is just 4 percent being utilized for the services to the elderly?

Dr. KLERMAN. We still have a way to go in reallocating available resources. At the same time, I would stress, in particular, that Federal funds for research have more than doubled and tripled in the past few years as well as the increase in services for training.

Senator PRYOR. Well, I think this hearing today is not a hearing attempting to get necessarily more money; this is one of those rare meetings where we are not asking for additional sacks of money, and so forth. This is a hearing where we are trying to reorder some priorities, and that is why we have had experts like you come in and that is why we wanted to ask you some of these questions. We appreciate your comments.

Senator Chiles.

Senator CHILES. Doctor, in your written testimony you mention the community support program. I understand that the program is geared to provide coordinated health and social services to adults who are severely mentally or emotionally impaired. I understand that in Florida, for instance, one of four of the deinstitutionalization projects is specifically aimed at the elderly, and a study has found that the mentally ill in nursing homes can often be able to live in other settings. Under the project, what kind of services does the client receive?

Dr. KLERMAN. I think Dr. Sharfstein can answer that.

Dr. SHARFSTEIN. I would be delighted to. The project in Florida, which is located in Miami, called Fellowship House, provides social rehabilitation service, home visits, and services which enable individuals to remain in their natural environment and not require intensive 24-hour care. They also provide a key component in the service system called case management, where there are individuals who assume the responsibility of coordinating all the Federal, State, and local agencies and the entitlement programs for handicapped individuals.

Senator CHILES. What would it take to use this model for former nursing home patients across the Nation? Has it reached the point of development where you can do that?

67-899 0 - 80 - 2

Dr. SHARFSTEIN. We have developed this at 14 other demonstration sites. There are a large number of elderly citizens who could survive and thrive in the community if the right kinds of service are there and the case management is there.

The idea of this particular pilot program is expanded in the Mental Health Systems Act, which would provide the resources and Federal leadership to greatly increase the initiative across the country. We would also attempt to influence current mental health policies, since State moneys are now focused in hospitals and large institutions. However, you may be aware that the State of Florida has recently budgeted $5.6 million for the development of five kinds of alternatives based on the community support program demonstration at Fellowship House in Miami.

Senator CHILES. Is this the type of program that the national plan for the chronically/mentally ill is supposed to develop?

Dr. SHARFSTEIN. We will be recommending certain changes in the social security titles, and that would also support development of these alternatives.

Senator CHILES. Those changes would be necessary to be able to channel some of the dollars that are now available for institutional care but would not be available for the outpatient form of it; is that correct?

Dr. SHARFSTEIN. Yes; in particular the support for case management services in the community are, I think, the key component and localities are beginning to reallocate these funds.

Senator CHILES. Do you think that we have demonstrated enough that we are ready to try to make those legislative changes that would be necessary?

Dr. SHARFSTEIN. Well, in terms of my own judgment, yes, I think that we are at that point. I think that the national plan will develop on incremental perspective in terms of what will be changed. The Mental Health Systems Act, as proposed by the administration and as now passed in the committees in the Senate and the House also, I think, contain as a core perspective that this is not a demonstration, that we are ready to move in this direction.

Senator CHILES. Thank you.

Thank you, Mr. Chairman.

Senator PRYOR. Senator Heinz.

Senator HEINZ. Yes, Mr. Chairman.

I have a question in particular for Dr. Klerman. I am interested in the project that NIMH is conducting with HCFA. I understand that it would demonstrate the effect of expanded medicare coverage on the cost and utilization of mental health services by medicare beneficiaries. Since you did allude to that, I believe, in your opening statement, I would greatly appreciate it if you could share with the committee here today some details about the demonstration. The details that I would be particularly interested in would be, first, where are these projects located? Second, how exactly do these projects expand coverage? For example, is it primarily inpatient or outpatient care that is enjoying expanded coverage in these demonstrations. And third, do you have any preliminary findings yet on the impact of expanded coverage on the cost, quality, and availability of mental health services?

Dr. KLERMAN. I wish I could answer all those questions, but we are still in the phase of initiating the demonstration. There is a commitment within the Department to determine the feasibility of reimbursing community mental health centers and other community based mental health services, including partial hospitalization on a cost-related basis as an alternative to institutionalization. Now $2.5 million has been committed by the Department to this demonstration and its evaluation and in fiscal year 1980, 45 communities around the Nation will participate. They have not yet been selected and the project has not actually begun in the field phase, so at this moment I can only describe our commitment and our intention. We do not have the results yet. We will have them probably within 18 months.

Senator HEINZ. You have selected the communities; is that correct?

Dr. KLERMAN. No; we are in the process of putting out an RFP and selecting the communities.

Dr. SHARFSTEIN. I think they are in the final phase of selection at this point. The actual selection has not been made. They may have been made this week, but as far as I know, there has not been a selection.

Senator HEINZ. Do I understand that you are putting out an RFP on an experiment?

Dr. SHARFSTEIN. No.

Dr. KLERMAN. Forty-five sites will be selected to insure representation and participation in terms of rural and urban and various economic and social factors. In addition, there will be an evaluation component and for that there will be an RFP putout.

Senator HEINZ. You anticipate that you will have some findings within 18 months?

Dr. KLERMAN. I think the timetable is within 12 to 18 months.

Senator HEINZ. Is this project going a little slowly?

Dr. KLERMAN. Well, we had hoped that we might have been able to get it started earlier than is currently the case.

Senator HEINZ. When was it first authorized or when was the commitment of which you spoke so warmly first made?

Dr. KLERMAN. The project was first discussed with then Secretary Califano about 1 year ago.

Senator HEINZ. I may be mistaken, but my understanding is that it may have been a little longer than that.

Dr. KLERMAN. Well, the genesis began with the President's Commission on Mental Health, which you alluded to in your opening statement, Senator. The current reimbursement program acts as a disincentive and it was that position which was reported to the President in 1978, 2 years ago.

Senator HEINZ. Yes; I introduced my legislation before the President got his report from his council. You know, we all like to think our ideas are new and original and that those presented by White House Conferences have never been discovered before. That, however, exaggerates the fact of the matter, as you and I both know. I do hope you will press ahead with the demonstrations and that there will be demonstrations and good ones.

The President's original budget proposals for both fiscal years 1980 and 1981 included the recommendation that medicare coverage be

expanded by raising the annual ceiling on outpatient care from $250 to $750 per year and reducing the beneficiary copayment from 50 to 20 percent on outpatient services. However, as I understand it, the administration proposal did not include extending provider status to community mental health centers, psychologists, and so forth.

In the revised March budget, did the President stick by his January budget on going from 50 to 20 percent?

Dr. KLERMAN. The understanding is that change is as you have identified.

Senator HEINZ. The second question is, are the HCFA demonstrations looking at extending provider status to psychologists, community mental health centers, psychiatric nurses, or social workers?

Dr. KLERMAN. Well, the main thrust of what you identify, namely, to get community mental health centers to provider status and also to allow for reimbursement where there is not direct physician supervision as part of these community programs.

Senator HEINZ. Which could include psychologists, psychiatric nurses, social workers.

Dr. KLERMAN. Yes; as a part of these community mental health centers or in outpatient clinics, but not necessarily as a free-standing provider.

Senator HEINZ. Would nonphysician provided care have to be community mental health center based in order to be reimbursable? Are all your demonstrations, in a sense, structured only to look at that particular option?

Dr. KLERMAN. Our concern in the demonstrations is with the delivery of service through organized facilities such as federally supported community mental health centers or community clinics. These demonstrations are not geared or focused at all upon the free standing professionals who are not part of an organized delivery component like a mental health center or a clinic.

Senator HEINZ. Mr. Chairman, I didn't mean to take so much time, and I apologize to all our witnesses.

Senator PRYOR. That is quite all right.

Senator HEINZ. Dr. Klerman, would it be possible for us to receive in more detail what in fact is going to be covered by your demonstration, the various kinds of delivery systems that are and are not considered here? It would be helpful to us if you could supply us with that information.

Dr. KLERMAN. Yes.

[Subsequent to the hearing, Dr. Klerman supplied the following information:]

MEDICARE MENTAL HEALTH DEMONSTRATION—STATUS REPORT, JUNE 18, 1980

Since the signing of a Memorandum of Understanding by the Assistant Secretary for Health (ASH) and principals in Planning (P) and the Health Care Financing Administration (HCFA) (copy attached) the demonstration project has advanced rapidly, to the point of near completion of requests for contract proposals—one for basic demonstration development, and a second for evaluation of both data and information generated by the project. HCFA and the National Institute of Mental Health (NIMH) are collaborating on the demonstration development; P and HCFA are collaborating on the evaluation. The demonstration development contract will go to a qualified 8–A (minority) firm this fiscal year. The evaluation contract is out for open bidding.

HIGHLIGHTS OF THE PROJECT

Purpose of demonstration: (1) To examine and evaluate the impact on utilization and medicare cost, of reimbursing mental health care to part B medicare beneficiaries on a cost-related basis rather than a fee-for-service basis, in a sampling of outpatient for partial hospital facilities; (2) to establish requirements for professional providers of covered services in the demonstration sites; (3) to determine the methods and rates of reimbursement congruent with the policy of the medicare program; and (4) to estimate the costs to medicare if this range of reimbursement were to be established nationally.

The project covers 3 years of demonstration in 45 nonhospital-based mental health facilities nationwide.

Sites include 15 NIMH-funded community mental health centers (CMHC's); 15 ambulatory mental health clinics—non-NIMH funded; and 15 partial hospitalization programs—non-NIMH funded.

There will be no dollar or visit limits for partial hospitalization services under the demonstration.

In one-half of the CMHC's and one-half the ambulatory clinics there will be no dollar or visit limits on covered services. The 20-percent coinsurance does apply.

In the other half of CMHC's (except for partial hospitalization) and ambulatory clinics, all covered mental health therapy services will be subject to the limit of $750 payment by medicare per benefit year as 80 percent of covered costs.

The annual part B medicare deductible of $60 is waivered for beneficiaries in all demonstration sites.

Covered services include diagnostic, therapeutic, and rehabilitative services, provided by or under the supervision of a qualified mental health professional, as defined for the demonstration, and such other services and supplies as are necessary for the diagnosis, treatment, or rehabilitation of the patient. The cost of necessary food and the preparation thereof is covered only for the partial hospitalization patients.

In sites where the annual $750 limitation applies, certain services, otherwise covered without dollar limit by medicare; e.g., speech and physicial therapy, will not be charged to the mental health benefit, even though prescribed in the site's treatment plan.

The Department has written the sites selected to extend an invitation to participate in the project.

HCFA is currently visiting a sampling of the demonstration sites to review and assess their cost reporting and claims processing capabilities.

The two contracts are expected to be let during the next 2 months.

The bulk of accounting, claims review, and data collection will be handled by staff at HCFA. Training site personnel, monitoring the quality and volume of project information and performance of the demonstration sites will be shared by HCFA and NIMH staff and the demonstration development contractor. The evaluation of the demonstration will be exclusively done by a separate contractor with close oversight by P and HCFA.

Contacts in the Department of Health and Human Services (HHS): Gail Robinson, ASP, 245–6604; Enid Hairston, HCFA, 594–7149; and Jack Burton, NIMH, 443–1596.

MEMORANDUM OF UNDERSTANDING

We, the undersigned, agree to develop and evaluate medicare demonstrations in cost-related reimbursement for ambulatory mental health and partial hospitalization services. This project:

Combines the two demonstrations so that a single setting that provides both ambulatory services and partial hospitalization need only be sampled once. (Sites providing only ambulatory services or partial hospitalization will also be included.)

Will proceed in three phases (fiscal year 1980, 1981, 1982 pending approval of new and continuation waivers by HCFA), with a report at the end of each phase as to whether sufficient information exists on which to base policy decisions and whether continuation of the project is necessary and appropriate.

Depends on medicare waivers for reimbursement of services (approval of waivers will be considered according to established HCFA waiver policies under the same rigorous research criteria as are applied to all HCFA-sponsored research and demonstration project proposals), Medicare's Office of Direct Reimbursement

to train the sample sites in cost finding and serve as fiscal intermediary, and the combination of an IPA and outside contracts for demonstration development and evaluation.

Funding plan

The funding plan included in the proposal takes into consideration HCFA's uncertainty in committing demonstration-evaluation funds in fiscal year 1980. The costs and funding sources for these demonstrations are as follows:

Phase I (fiscal year 1980, 1 year)—employment of an IPA to serve as project coordinator: $30,000 (P); employ the services of the Office of Direct Reimbursement (ODR): $250,000 (P); employment of a demonstration development contractor: $300,000 (ADAMHA); employment of the demonstration evaluation contractor: $420,000(P); and medicare waivers (45 sites, three quarters): $2.25 million estimated (HCFA).

Phase II (fiscal year 1981, 1 year)—continued employment of an IPA: $30,000 (P); continued employment of ODR: $200,000 (HCFA); continued employment of a demonstration development contractor: $300,000 (ADAMHA); continued employment of a demonstration evaluation contractor: $420,000 (P); and medicare waivers (45 sites, four quarters): $3.5 million estimated (HCFA).

(Note that if 15 more sites have to be added (after evaluation of phase I data), costs for ODR and the contractors will increase by $310,000; waivers costs will increase by an estimated $1.3 million.)

Phase III (fiscal year 1982, 6 months)—continued employment of ODR: $100,000 HCFA); employment of the demonstration development contractor: $160,000 (ADAMHA); employment of the demonstration evaluation contractor: $260,000 (P); and medicare waivers (45 sites, two quarters): $1.75 million estimated (HCFA).

(Note that if 15 more sites are added in phase II, costs for ODR and the contractors will increase by $160,000; waiver costs will increase by an estimated $700,000.)

Description of project

This medicare mental health demonstration project is an interagency effort among P, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), NIMH, and HCFA to determine the feasibility of reimbursing freestanding community mental health centers (CMHC's) and other organized mental health settings on a cost-related basis, without the requirement of direct physician supervision.

Approximately 45 mental health services delivery sites will receive medicare waivers for cost-related reimbursement for services to the elderly and disabled. These sites will consist of:

Fifteen freestanding community mental health centers providing at least the five initial services required by current law, including partial hospitalization. Partial hospitalization would consist of a stay in a CMHC, or other like center, or 4 or more hours a day over an extended period of time. It could vary from every day to a few days per week. Included in this stay could be such activities as group therapy and occupational therapy.

Fifteen smaller, less comprehensive freestanding organized mental health ambulatory settings which meet, at a minimum, the site physician supervision standards in the Rural Health Clinic Act.

Fifteen providers of partial hospitalization for mental patients that do not operate in conjunction with an organized ambulatory setting.

What is to be learned from the project

To establish standards for professionals providing services, and to determine methods and rates of reimbursement congruent with the policy of the medicare program.

To determine the effect of expanded coverage on utilization of services by the medicare eligible population.

To document the cost to medicare for this expanded range of reimbursement for ambulatory mental health services.

To estimate the costs to medicare if this range of reimbursement was to be established nationally.

DEMONSTRATION AND WAIVER AUTHORITY

Section 402(a) of the Social Security Amendments of 1967, Public Law 90–248, as amended by section 222(b) of the Social Security Amendments of 1972, Public

Law 92–603, (42 U.S.C. 1395b–1(a)), authorizes various types of experiments and demonstration projects. Specifically, that section reads as follows:

"Section 402. (a)(1) The Secretary of Health, Education, and Welfare is authorized, either directly or through grants to public or nonprofit private agencies, institutions, and organizations or contracts with public or private agencies, institutions, and organizations, to develop and engage in experiments and demonstration projects for the following purposes:

(A) To determine whether, and if so which, changes in methods of payment or reimbursement (other than those dealt with in section 222(a) of the Social Security Amendments of 1972) for health care and services under health programs established by the Social Security Act, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services.

(B) To determine whether payments for services other than those for which payment may be made under such programs (and which are incidental to services for which payment may be made under such programs) would, in the judgment of the Secretary, result in more economical provision and more effective utilization of services for which payment may be made under such program, where such services are furnished by organizations and institutions which have the capability of providing—

(i) comprehensive health care services,

(ii) mental health care services (as defined by section 401(c) of the Mental Retardation Facilities and Community Health Centers Construction Act of 1963), * * *"

Section 402(b) authorizes the Secretary to waive compliance with title XVIII provisions in order to conduct demonstrations authorized under section 402(a). Specifically, that section reads as follows:

"Section 402. In the case of any experiment under subsection (a), the Secretary may waive compliance with the requirements of titles XVIII, XIX, and V of the Social Security Act insofar as such requirements relate to reimbursement or payment on the basis of reasonable cost, or (in the case of physicians) on the basis of reasonable charge; and costs incurred in such experiment in excess of the costs which would otherwise be reimbursed or paid under such titles may be reimbursed or paid to the extent that such waiver applies to them (with such excess being borne by the Secretary) * * *"

PROJECT MANAGEMENT

Responsibility for managing the project will be allocated as follows:

Project and contract officers, demonstration component. HCFA will have responsibility for the development of the demonstration (including all ODR functions) as well as for the implementation and monitoring of the project. NIMH will designate an associate project officer to participate in the demonstration project development implementation and monitoring. HCFA will designate project and contract officers to perform the necessary duties, including approving and signing all vouchers and approving deliverables, and to consult with P and ADAMHA in all matters affecting the demonstration component and the integrity and outcome of the overall project.

Project and contract officers, evaluation component. P will have responsibility for the management of the evaluation component. HCFA will designate a co-project officer. The ASPE and HCFA project officers will make all decisions jointly and will have dual responsibility for signing vouchers, approving deliverables, etc. P will designate a contract officer and will be responsible for awarding the contract. HCFA and P will agree to consult with ADAMHA in all matters affecting the evaluation component and the integrity and outcome of the overall project.

Site selection and services analysis. ADAMHA will develop criteria for and propose sites for the demonstration and will provide information on the services provided at each proposed site. ADAMHA will designate a staff person to peform the necessary duties and serve as a contact for P and HCFA staff. The final selection of sites must be approved by the demonstration project officer.

Project coordinator. The project coordinator, Gail Robinson, will work with the project officers and the ADAMHA designee to insure overall coordination of the various components. This will necessitate field visits and time spent on the demonstration development, ODR, and evaluation components. She will attempt to resolve conflicts between the components that affect the integrity and outcome

of the overall project. If resolution is not possible she will surface these conflicts to the project management team.

Project management team. HCFA, ADAMHA, and P will each designate representatives to serve on the project management team, as follows: HCFA—Barbara Cooper, acting director, Office of Demonstrations and Evaluations, ORDS; ADAMHA—Tom Vischi, acting director, Division of Treatment, Office of Program, Planning and Coordination; and P—Bonnie Lefkowitz, director, Division of Health Resources and Services Analysis.

This team will provide general direction for the project and supervision for the project coordinator and project officers; review each RFP, contract, and work product; and attempt to resolve conflicts that affect the integrity and outcome of the overall project. Any member of the team may convene the team as she/he deems necessary.

JOHN L. PALMER,
Acting Assistant Secretary for Planning and Evaluation.
JULIUS B. RICHMOND,
Assistant Secretary for Health.
LEONARD D. SCHAEFFER,
Administrator, HCFA.

Signing of this document by all three signatories was completed February 4, 1980.

Senator HEINZ. Thank you.

Senator PRYOR. Senator Burdick.

Senator BURDICK. One question.

Good to see you, Doctor. On page 2 of your statement you say: "Among the prominent barriers to mental health care services for the elderly are the following," and then you list several. I am referring to one of those listed. "Inadequate training in geriatrics among health care personnel leads to inaccurate or misleading diagnoses and treatment."

What do you recommend that we do to get adequate training in geriatrics?

Dr. KLERMAN. I think Dr. Cohen can provide that.

Dr. COHEN. The whole area of training, I think, is a particularly interesting one in terms of what has been going on in the past several years, in geriatric psychiatry especially. I think this is one of the areas that reflects the historical turning point that I think we are at in the field of mental health and aging. To be specific, up until 1978, in the history of the country, there was only one specialty training program in geriatric psychiatry. By the next year, 1979, stimulus and funds from NIMH in conjunction with interest in the field led to a growth of programs from one to seven, which represented quite a dramatic change. At this point, that number has gone beyond 10. The change is significant relative to what had been.

Obviously the need that remains is enormous, but I think the most significant thing is the indicator of a new direction.

Senator PRYOR. I know you have some questions.

Senator BURDICK. Of the other witnesses.

Senator PRYOR. We are going to ricochet here for just a moment and allow Senator Burdick to ask Dr. Weinberg a question because I think he may have to leave, and then I want to ask one or two questions to the three individuals here. So you feel free, Quentin, to ask Dr. Weinberg a question.

Senator BURDICK. Doctor, I read your statement briefly, and I find on page 20 the following statements. You say at the top of the page:

But with a service system in place and appropriate reimbursement mechanisms we must have appropriate trained and adequate numbers of psychiatrists, other physicians, and other mental health professionals and paraprofessionals to help provide the care to the mentally ill elderly.

Then further down on the page you say:

Presently, only two U.S. medical schools have required courses in geriatrics.

You also say:

I am pleased to note in this context the existence of legislation developed by a member of this committee Senator Burdick, which would encourage the establishment of geriatric education programs in medical schools. I concur with him that the general practitioner, too, must become educated to the special health care needs of the older person and would encourage him to consider adding the area of geriatric psychiatry specifically to his proposed legislation.

Now my question to you, Doctor, is a five-part question.

At the present time, how large a corps of experts are available to teach geriatrics mental health? Is it already expanding, or just a few people in the country with little expertise? If there are only a few experts, how fast is the field growing now without any major Federal input?

Dr. WEINBERG. Thank you, Senator. I am fully aware of your continued interest in the field of education and I am very grateful to you as an educator in that area. I would like to reply to your questions.

Indeed, the Center for the Study of Mental Health of the Aging has made me a senior scholar to its faculty. One of the things I have done is go through the country taking a look at the schools to see what is being done as far as geriatric training and education within the schools proper. There is a vast amount of knowledge at present about the differences between the status of the eldery and that of other adults. There is a vast amount of expertise and knowledge in the basic sciences to indicate our differences, as one gets older, that needs to be paid attention to. There is, for instance, the fact that various organ systems have various clocks in the human being, meaning by that that the cardiovascular system has one clock, the genital-urinary tract another clock, and so on, and they don't all age at the same level and the same time. Therefore, we need to know the physiology of the individual as he gets older.

A great deal of knowledge is available and is not being taught in the various schools. Wherever I go, I find out that there is a scarcity of teaching, specifically of geriatric medicine and geriatric psychiatry, which I am particularly interested in. Yet every place seems to provide us with experts, people who do know, particularly in the clinical area, those who will have to provide to the patients expert knowledge and expert care.

As Dr. Cohen has indicated just a while ago, there is a growing number of places where we are teaching geriatric psychiatry, but in the teaching of geriatric psychiatry it is not just psychiatry that is involved, but also the rest of medicine, because no other field in psychiatry involves as much knowledge of the medical state as the older person because there are a number of illnesses that come together at the same time. We need to differentiate between organic differences of the brain and those that are functional. Therefore, the psychiatrist must know medicine and must be able to differentiate between the one and the other.

Just a while ago, Senator Pryor had indicated that there are such things as depressions that increase as far as the elderly are concerned. Those of us who work in the field of aging know that there are differences between the field of depression and depression and grief that takes place with the elderly upon losses that they place in their lives and one needs to diagnose. We need the experts to be able to deal with grief, sadness, and depression because one requires one type of approach and another requires another type of approach. We must not lump all of those people into the same area.

Therefore, as Dr. Cohen indicates, there are now 10 centers that are teaching geriatric psychiatry and they at the same time invade, if you will, the rest of the medical school by providing not only the knowledge to them, but also demanding of the residents, primarily residents in family care, residents in urology, and so forth, to participate in these studies. So it is increasing, but there is an enormous need for a great deal of what you have been doing in this area, attempting to increase the needs for training people throughout the country; otherwise, we are just providing one another with a smattering of ignorance and not providing the proper care that the elderly deserve.

Senator BURDICK. In your statement, you say there are only two U.S. medical schools that require these courses. The gentleman over here said it was up to 10 now in different areas.

Dr. COHEN. The difference would be in looking at medical schools as opposed to departments of psychiatry.

Dr. WEINBERG. That is right.

Senator BURDICK. You are making some progress. How do we increase it? How do we get more schools open in this area?

Dr. WEINBERG. One of the things recently has been a study called the Beason report here in Washington that has been stimulating the medical schools to increase within the curricula the knowledge of medicine, the knowledge of the differences between the adult and the elderly themselves. Furthermore, an intersting phenomenon is—I am trying to encourage them to do so, but we have also been asking the national examination boards to increase the number of questions on geriatric medicine within their examinations, and if indeed that will be increased, then there will be a need for the schools to teach their students, who will have to pass those examinations in order to know something about the elements in aging.

We do the same thing in psychiatry. I have been stimulating them to increase the number of questions about the elderly within their examinations in order to be certified. Hence, there is going to be a demand on the part of psychiatrists and physicians to know more about a particular field. Certainly, in the area of continuing medical education, there has been an increase in this school that I teach. I have asked that we must increase within our medical student body, from the very first year on, to learn not only the biology of aging, but also the psychology and the psychosocial aspects of the individual.

Senator BURDICK. A bill that has been introduced, S. 711, would urge medical schools to include this. Some of the others would extend this to schools of dentistry and pharmacology. On the other hand, however, many in Congress want the Federal Government to end the institutional support programs.

Given the fact that we have very few limited Federal dollars, very limited Federal dollars, what do you think would be the best thing the Federal Government can do to encourage a better understanding of geriatrics among health professionals? We agree with all you said. Now how do we do it?

Dr. WEINBERG. As experts, we always are able to diagnose rather than necessarily be able to treat the situation, as you know. I think that the very demands of the situation are going to increase the particular knowledge. As we enter a general hospital at the present time, you might be interested to know that the American Medical Students Association has been clamoring for more content in geriatric medicine, because when they enter the general hospital, more than 30 percent of the beds in a general hospital are occupied by people 50 years of age and above. If you eliminate obstetrics, more than 50 percent of the people occupying the beds in the general hospital—I am not speaking of psychiatric hospitals—are 50 and above and 60 and above. Therefore, there is an increased demand to know a great deal.

The Federal Government, in the sense that it does provide support for the various schools, could in its regulations demand that there be an increase of geriatric medicine in totality in their curricula as one of the requirements, and I would strongly urge that.

Senator BURDICK. I thank you, Dr. Weinberg.

Dr. WEINBERG. Thank you, Senator Burdick.

Senator BURDICK. I thank you, Mr. Chairman, for taking me out of order. You know we have these conflicting hearings.

Senator PRYOR. We understand that.

I think Senator Burdick has raised a very valid line of questions and I just would like to add an observation. In the State of Arkansas, which is the State second only to the State of Florida in the percentage of its population over 60, to the best of my knowledge there is only one physician in the State of Arkansas who holds himself out as a specialist in geriatric medicine or who has any degree of specialty in that practice, and this gentleman is in the northern and northwestern corner of the State. We see really an entire void there of real trained individual practitioners who specialize in geriatrics.

Dr. WEINBERG. Senator Pryor, may I interject. We see more and more people coming up in the various States who program themselves to be geriatricians now. They say through their own personal experience what I must say, which is that we need to educate many of these people that are professing now to be geriatricians. We need to educate the cadre of specialists, and this is what we are involved with, and that is, the center for the study is very much interested in teaching the cadre of educators to educate the physicians and other professionals in geriatric medicine and in geriatric psychiatry.

Senator PRYOR. I hope we can really inspire that program in some way to move along very quickly and effectively.

Let me move back to Dr. Klerman and his group just for a moment. I have here a two-volume set of books entitled "Families Today" published by the National Institute of Mental Health. I assume that these volumes are published in preparation for the upcoming White House Conference on Families or in conjunction with the White House Conference on Families. I am a little bit disturbed. I am very proud that you would take the time to publish these two volumes be-

cause I think there are some well-written and reasoned articles, about 40 I think total, in the two volumes. The problem is, there is only 1 article out of the 40 that deals specifically with the elderly.

When we talk about the families today, I hope that that is not the priority that the National Institute of Mental Health or this Government is placing on the elderly part of the family itself. I wonder if you have a comment on that only one article dealing with the elderly.

Dr. KLERMAN. I would hope that you do not take that publication as an indication of what our concerned interest and commitment is.

Senator PRYOR. I am hoping it does not indicate that.

Dr. KLERMAN. I think the fact that NIMH has established a special center on the health needs of the elderly is an indication of our response to the findings of the Civil Service Commission and the Congress, that the funding of that center has increased steadily in the past 4 or 5 years. It has become more diverse in its program of not only biological research, but psychosocial research, including research on the family.

In addition, it is also important to recognize the activities of the National Institute of Aging, of which Dr. Butler is the Director, which also has an extensive program on general issues in the biology and psychology of aging, not only that which has to do with mental health. We could provide you with more information on the family aspects of what we are doing, including research on family treatment and family aspects.

Senator PRYOR. I think our concern is that we just don't want to see the elderly being given a token few pages in these volumes, nor a token thought or a passing thought, when it comes to thinking about the families in this country as en entity, because the upcoming White House Conference on Families certainly must, I think, place major concern and major emphasis upon the elderly and how they interchange with the family itself as an entity.

Without objection, the prepared statement of Dr. Klerman will be entered into the record at this point.

[The prepared statement of Dr. Klerman follows:]

PREPARED STATEMENT OF DR. GERALD L. KLERMAN

Mr. Chairman and members of the committee: Thank you for the opportunity to appear before you today to present testimony on "Aging and Mental Health: Overcoming Barriers to Service." I shall share my thinking with you with respect to the special focus of policies, activities, and programs of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), particularly as they relate to this area of vital national importance. To assist me in reviewing the agency's programs and activities on aging and mental health are Drs. Gene D. Cohen, Chief, Center for Studies of the Mental Health of the Aging, National Institute of Mental Health (NIMH) and Steven S. Sharfstein, Director, Division of Mental Health Service Programs, NIMH.

More than 20 million people, one-tenth of the population of the United States, are 65 years of age or older. This population group is growing more rapidly than the population at large, with studies indicating that by the year 2000 approximately 12 percent of Americans will be over 65 years of age with the highest rate of growth being for those over 75.

Biomedical and psychosocial problems associated with old age affect, or will affect, almost everyone. Even in the healthy elderly citizen, a gradual decline of physical abilities with age is expected. This decline, coupled with important psychosocial changes, make adjustment extremely difficult for many aging persons. Recent studies confirm the fact that the incidence of mental illness and impairment rises with age. As a result, those Americans over 65 years of age

reflect the highest prevalence of mental disorder, have the highest suicide rate, and occupy 20 percent of all public mental hospital beds. It is estimated that two-thirds of the 1.1 million elderly nursing home residents have a significant mental health problem.

Among the prominent barriers to mental health care services for the elderly are the following:

—Low benefit levels for mental health reimbursement in public and private insurance plans promote inappropriate placements and discourage other modes of care.

—Inadequate training in geriatrics among health care personnel leads to inaccurate or misleading diagnoses and treatment.

—Among some mental health professionals there are negative attitudes toward treating the elderly.

—Inadequate coordination among various health and social services agencies in planning for the comprehensive needs of deinstitutionalized or non-institutionalized elderly mentally ill which result in no care or gaps in care.

—Lack of mental health care programs in the community or inability to travel to such programs where they exist can create an access problem for the elderly.

—Fear of stigma and/or institutionalization may prevent many from seeking mental health care on a self-referral basis.

Aging, though long a program area of NIMH has grown in recent years to a major Institute activity. Recent events of significance in the development of the NIMH program which highlight certain issues and barriers concerning services to the elderly include:

—August 1975—Established the Center for Studies of the Mental Health of the Aging to coordinate Institute activities in aging.

—1975–76—National conference planned and conducted in the areas of research, training, and services in mental health and aging, to effect an agenda for the Center.

—1977—$2 million in the supplemental appropriation for fiscal year 1977 was provided to support research in mental health and aging.

—1978—Report of the HEW Secretary's Committee on the Mental Health and Illness of the Elderly (as mandated in Public Law 94–63), transmitted to the Congress.

—1978—Report of the President's Commission on Mental Health, highlighting the elderly as a major underserved population published and implementation of recommendations begun.

—1978—Center for Studies of the Mental Health of the Aging elevated from a coordinating unit within NIMH to full operational status with responsibility for administering grants in research and training.

—1979—Aging identified as a priority target population for clinical training initiatives, in line with recommendations of the President's Commission on Mental Health.

—1979—Participating in a 3-year project with the Health Care Financing Administration (under the leadership of the Office of the Secretary) to demonstrate the effect of expanded medicare coverage on the costs and utilization of mental health services by medicare beneficiaries.

—1980—A Departmentwide initiative to develop a National Plan for the Chronically Mentally Ill is underway. The special needs of the elderly will be addressed in the National Plan.

I believe it is important, at this point, to discuss with you the policies, program activities, and directions of the Center for Studies of the Mental Health of the Aging (CSMHA), the Community Mental Health Centers Program (CMHC), and the Community Support Program (CSP), three important programs of NIMH.

CENTER FOR STUDIES OF THE MENTAL HEALTH OF THE AGING

The CSMHA is the focal point in NIMH for aging programs. The major role of CSMHA is to stimulate, coordinate, and support research, training, and technical assistance efforts relating to aging and mental health. The formal establishment and support of the Center is indicative of the substantial programmatic and administrative priority of mental health and the aging in this administration.

Activities of the Center fall into four categories: Research, research training, clinical/services training, and technical assistance.

Research program

The Center supports studies which have a primary focus on the mental health and illness implications of the aging process and the elderly. It supports a wide-ranging, multidisciplinary set of studies which have both theoretical and policy or applied implications.

Research training

National Research Service Awards, including individual fellowships and institutional awards at the predoctoral or postdoctoral levels, are given to provide support for the training of research scientists in the area of mental health and aging.

Clinical/services training

The Center's program in mental health services human resources development and training focuses on training efforts designed to improve mental health and related services to the elderly within both the established mental health service delivery system (e.g., State mental hospitals, community mental health centers, etc.) and the mental health-related support systems (e.g., senior centers, long-term care facilities, etc.). Grants are available in two major categories: Mental Health Services Manpower Education/Training, and Mental Health Services Manpower Research and Demonstrations.

Special projects

Special projects are supported under both of the preceding clinical/services training categories and are for the purpose of supporting conferences, seminars, or workshops that promote discussion, sharing of information, and exploration of issues and approaches for addressing training needs in mental health of aging.

COMMUNITY MENTAL HEALTH CENTERS (CMHC) PROGRAM

The program provides support for the initiation and development of comprehensive community mental health services to designated populations, irrespective of age, sex, ethnicity, and ability to pay. Since its inception in 1965, the program has funded 763 centers that have provided services to 111 million citizens, approximately one-half of the Nation's population.

Starting in fiscal year 1976, newly funded CMHC's were required by Public Law 94–63 to provide, or assure the availability within the catchment area of, specialized services for the elderly. Although adequate data are not available to assess the full extent of direct services that are provided to the aged, in 1979 approximately 112,000 elderly citizens received services in CMHC's. In addition, the Institute has provided special technical assistance to approximately 80 CMHC's, with respect to providing geriatric services to the elderly.

In addition to the direct services provided by CMHC's to the elderly, there are consultation and education services as well. These include a wide range of activities which are designed to develop effective mental health programs in a center's catchment area, promote the coordination of mental health services among the various entities providing related services, increase the awareness of residents of the nature of mental health problems and available services, and strengthen the mental health skills of other agency personnel, thereby reducing the need for direct services in the CMHC. In the month of February 1978, 13,000 hours of consultation were provided to facilities and agencies concerned with programs for the aged.

All CHMC's currently receiving Federal funds are monitored. When less than anticipated use of CMHC services by the elderly is detected (through site monitoring, State plan review, or grant application review) specific attention is focused on determining whether discriminatory policies or procedures or staff attitudes are resulting in denial of services. To assist CMHC administrators and staff to upgrade skills and counter any restrictive attitudes, NIMH has developed technical assistance courses in developing, organizing, and delivering mental health services to the elderly, and has prepared resource materials. These activities have been undertaken on a national level by the NIMH Staff College.

Services research resources are also directed to improvement of service for the aged. Three of the projects NIMH has recently supported are concerned with: (1) The development and evaluation of an unstructured neighborhood social center for the urban elderly which provides immediately available social and health services, diagnostic screening, and case finding; (2) the further

definition of coping strategies that are effective in maintaining self-esteem by the elderly, and their interaction with situational factors and staff attitude; and (3) the development of instruments to assess the social and environmental factors in sheltered care settings for the elderly and their relationship to personal functioning.

COMMUNITY SUPPORT PROGRAM (CSP)

CSP guidelines (published on November 12, 1977), define the target population of that program defined as "adults with a severe or persistent mental or emotional disorder that seriously limits their function capacities relative to primary aspects of daily living such as personal relations, living arrangements, work, recreation, etc." The aging issue is clearly addressed in CSP policy in that elderly persons are included in the target population if they meet the general criteria, but excluded if they have physical or mental conditions requiring skilled or semi-skilled nursing care. Therefore, while the elderly are not the specific focus of the program, they often fall within the definition of the target population.

Several States have conducted or are in the process of conducting needs assessments which identify the numbers of chronically mentally ill in the State or in a specific demonstration area. For example, the New York State CSP project has conducted a large data collection and has analyzed the population of three demonstration sites. New York's findings cite that 21 percent of clients being served are 65 or over, and that older clients are more likely to receive case management services than other age groups. In Florida, one of four desintitutionalization projects is strictly targeted for the elderly. This program, entitled the Gerontology Project, will start in mid-1980 and will aid elderly citizens who are losing physical and mental capabilities. Florida also conducted a study which found that many of the mentally ill in nursing home placements might be able to live in other kinds of facilities.

In terms of CSP program development the various contractors in CSP projects have addressed the aging issue with a variety of approaches. A few of the States have been actively involved in developing specialized services for the elderly in the target population. Other States have involved groups representing the elderly in planning future CSP activities related to the elderly.

In summary, the intended focus of the Community Support Program is on improving and coordinating mental health and human service delivery for severely disabled adults. An unintended spinoff, however, has been that improved systems coordination has often enhanced mental health and other human services for the elderly in CSP States and local demonstration areas.

THE MENTAL HEALTH SYSTEMS ACT

In addition to our existing mental health programs which deal with the elderly, the Senate Committee on Labor and Human Resources on April 24 of this year favorably reported S. 1177, the Mental Health Systems Act. As reported, the act would give the Secretary additional new authorities to enter into agreements with public and nonprofit private entities to provide mental health and support services to the elderly. Among the many services authorized are:

—Mental health needs assessments and services.

—Insuring the availability of personnel to provide mental health and support services to the elderly.

—Coordinating the provision of mental health and related support services with the activities of the area agency on aging (as defined in the Older Americans Act) and other Federal, State, and community agencies offering services.

—Providing mental health services to elderly individuals in, and staff training for employees of, nursing homes, intermediate care facilities, boarding homes, senior centers, and ongoing self-help groups and crisis support programs.

—Providing medical differential diagnoses to distinguish individuals' needs for mental health services from needs for other medical care.

I believe these new flexible authorities, if enacted, will greatly facilitate our ability to serve the elderly in future years.

I would like to discuss the activities of the other two Institutes with respect to the elderly. These Institutes. the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), along with NIMH comprise the Alcohol, Drug Abuse, and Mental Health Administration.

DRUG ABUSE

In the drug abuse area, the general view is that while the younger generation is prone to using greater amounts of illicit drugs such as marihuana and certain legal drugs and/or alcohol, the drug problem among the elderly is more often one of misuse, rather than the deliberate abuse, of legally available, prescription drugs. Education and information provided to both the elderly and the health care professional can help to prevent drug misuse.

Those over 65, who comprise 10 percent of the population, now consume about 25 percent of the medications taken in the United States. As the largest consumers of legal drugs, proportionate to their percentage of the total population, the elderly are at risk for dependency problems involving a wide variety of substances. Serious problems may also result from overuse of nonprescription drugs alone or in combination with prescription drugs and alcohol. These problems might result from a lack of knowledge on the part of elderly persons as to the interactive effects of mixing drugs.

NIDA has supported the development of a successful prevention project aimed at just this problem. The Elder Education Project, which was funded by NIDA and developed by senior citizens, has provided an attractive kit, a film, and discussion materials for use in the community. These materials are aimed at promoting better use of medicines by the elderly through education. In addition, the Institute's Manpower and Training Branch has developed and disseminated two documents, one entitled "Drug Misuse and Abuse Among the Elderly" was developed for medical staff, social workers, and volunteers; the other is entitled "Improving the Use of Drugs by Elderly Patients," is aimed at pharmacists and pharmacy students.

The NIDA demonstration research program has produced a number of publications as a result of recent grants, contracts, and conferences, including: "The Aging Process and Psychoactive Drug Use," "A Study of Legal Drug Use by Older Americans," "A Survey of Drug Taking Behavior of the Elderly," and "Drug Abuse and the Elderly: Perspective and Issues." Currently a study of drug use patterns and related behaviors, among a representative sample of elderly citizens in Houston, Tex., is being supported at a cost, over a 2-year period, of $316,824. This grant includes the aged as one of the groups in a study of driving impairment related to drugs of abuse. The activities are shared and coordinated with the Administration on Aging, the National Institute on Aging, and the Institutes of ADAMHA.

In July 1980, a small NIDA-supported technical review group of experts from outside the Federal Government will meet to discuss important research findings on drug abuse among the elderly, as well as methodological issues in planning and conducting future research.

In fiscal year 1981, NIDA plans a contract to explore the psychosocial characteristics of the elderly who become involved in drug misuse and abuse. Its focus will be on illicit drugs. Further, it is envisioned that a set of personality typologies can be depicted for those elderly persons at risk of drug misuse and abuse. Several broad classes or types are potentially anticipated. These research activities will approximate $106,000.

Public Law 96-181, the recent amendments to the Drug Abuse Office and Treatment Act of 1972, reauthorizes the programs of NIDA and directs the Institute to develop programs to discourage certain high risk populations from abusing drugs. In carrying out these provisions, the Secretary is authorized to give priority to grant applications for the prevention and treatment of drug abuse and drug dependence of the elderly, women, and youth. NIDA officials expect that 25-35 percent of the new prevention grants authorized by Public Law 96-181 will support projects directed to the elderly, women, and youth. Also, NIDA will encourage grants to supply additional consumer awareness materials for the elderly, and to evaluate prevention strategies designed to meet the needs of the elderly as a group.

ALCOHOLISM AND ALCOHOL ABUSE

Survey data for the years 1971 to 1975 indicate that the percentage of persons 65 years or older who drink alcoholic beverages declines to 48 percent among men and to 32 percent among women. The percentage of these persons who experience problems with the use of alcohol (including alcoholism) also declines—to 2 percent among females, but to a much higher 9 percent for males. This mean that there are approximately 1 million problem drinkers among the aged population.

But as the proportion of the elderly within the population grows in the years ahead, there are preliminary indications that alcohol problems among this age group will increase as well.

Although alcoholism is statistically less of a problem for the elderly than it is for younger Americans, it is characteristically more complex, and in some cases, more insidious. Elderly alcoholics and alcohol abusers can be distinguished as belonging to one of two groups: Those who began drinking at an early age, and those who began drinking later in life. The "early-onset" alcoholics are similar to younger alcoholics in their reasons for drinking, in their drinking patterns, and in the quantity of alcohol they consume. On the other hand, "late-onset" alcoholics or alcohol abusers usually drink in response to the stresses of aging. These are well known—the loss of occupation, high incidence of poverty, increased susceptibility to debilitating physical disease, the loss of status and sense of uselessness in a youth-oriented society, changes in living arrangements, and personal losses that increase with advancing age.

The complications of alcoholism and alcohol abuse in the elderly are well known. The metabolism rate decreases. They frequently suffer nutritional deficiencies. The somewhat anesthetic effect of alcohol can serve to mask pains that would otherwise be an indication of an acute condition. The elderly consume a disproportionate amount of prescription and over-the-counter drugs, often self-administering excessive quantities—and thereby increasing the risk of alcohol-drug interaction. And they may suffer from self-neglect, falls, and confusion. Diagnostic problems constitute perhaps the greatest barrier to treatment of these individuals.

In the past the elderly have been less visible because of their relatively smaller population size, and they are sometimes less vocal. However, as both the numbers and percentages of elderly increase so, too, are the interests and concerns of the aging assuming greater importance in American life.

Congress, this last year, placed an even greater emphasis and focus on the problems of alcohol abuse by the elderly. It required State alcohol advisory councils to include representatives of the elderly. It required States to survey the need for alcoholism services for the elderly and provide assurance that they will provide programs to meet these needs. It further directed the Secretary to encourage and to give special consideration to applications for prevention and treatment projects for the elderly.

In 1978, over 8,000 persons 65 years and older received services through NIAAA-funded treatment programs. The Institute is currently devoting approximately $500,000 for treatment projects targeted specifically to the elderly alcoholic and alcohol abuser. In addition, elderly persons are served by States through other programs. The NIAAA will continue its efforts in supporting treatment of the "early-onset" elderly alcoholic and alcohol abuser. It will also strengthen its efforts to train care givers to recognize the "late-onset" elderly alcoholic and alcohol abuser to provide more appropriate intervention. Several such training projects are now under consideration and development.

The Institute is also supporting approximately $140,000 of research targeted specifically to this elderly population. Through these efforts, it is hoped to gain an increased understanding of the quantity of alcohol some elderly consume, the situations in which drinking occurs, and physiological changes that take place. The Institute is also supporting a $78,000 prevention grant focused on alcohol use by residents in approximately 40 nursing homes in the Boston area and will determine ways in which such settings can be changed, if necessary, to include more humane policies and practices.

You may be aware that the National Council on Alcoholism has formed a Blue Ribbon Study Commission on Alcoholism and the Aging, chaired by the Honorable Wilbur Mills. The Institute welcomes this initiative by the private sector and looks forward to providing continued assistance to this important effort.

In addition, NIAAA is engaged in other activities related to the elderly. The Institute serves on the Ad Hoc Interagency Committee on Research on Aging whose purpose it is to coordinate the Federal research efforts regarding aging. Preliminary discussions are also underway with the Administration on Aging and the Office of Human Development on means of collaboration. Through this the Institute would facilitate contact within the States among State aging authorities, State alcoholism authorities, and State manpower development coordinators to address and meet the problems of the elderly alcohol abuser and alcoholic.

67-899 0 - 80 - 3

Earlier I discussed the three major programs of NIMH that are responsive to the special needs of the elderly. It is important to stress the collaboration and joint interests that these programs share, and to identify the interagency collaboration as well.

COLLABORATION

There are a number of cooperative efforts currently being pursued with respect to the elderly. For example, not all research in mental health and aging can or should be supported or administered by the Aging Center. In fields with strong and well established technologies, such as psychopharmacology and epidemiology, specialized expertise already exists. Similarly, certain research issues are best conceptualized as life-course or adulthood issues, in which the elderly fit only as part of the study. In these types of circumstances, the Aging Center has established mechanisms for joint-funding while still maintaining fiscal control of the funds. Projects have been cofunded with other programs of the Institute, with the National Institute on Aging, the National Institute of Neurological and Communicative Disorders and Stroke, and with the Administration on Aging. In this way the total aging effort is expanded and multiplied. As with research, not all clinical training in mental health and aging can or should be supported or administered by the Aging Center. In prior years, Center funds have been transferred to the NIMH Manpower and Training Division to support aging-related training.

The Center for Studies of the Mental Health of the Aging has conducted a technical assistance project in four regional offices during the past 2 years. This project has been supported through 2 percent technical assistance funds available through the Community Mental Health Centers Act, as amended. The projects have been jointly administered by the individual alcohol, drug abuse, and mental health units in the 10 Public Health Service Regional Offices and the Center on Aging. The focus of the technical assistance is CMHC's, and the objective is to assist the CMHC's in developing their capabilities to deliver mental health service to the elderly. The Center collaborates with regional office staff in selection, orientation, and evaluation of the technical assistance program. A total of 39 CMHC's have directly participated in the program, at a total expenditure of $60,000 for the past 2 fiscal years. In fiscal year 1980, two additional regional offices will participate in the project at a proposed cost of $15,000. Based on what is learned from this activity, the Aging Center expects to transfer this knowledge to all 763 CMHC's through publications, workshops, and consultation.

The Center also provides technical assistance through consultation for the development and stimulation of research and training applications focused on the mental health of aging persons. Researchers and directors of training programs are encouraged to contact the Center for discussion of ideas for new research or training projects.

Major technical assistance efforts are available to public and private agencies at regional, State, and local levels with the objective of improving programs affecting the mental health of the elderly, especially the delivery of such services by community mental health centers.

There are many Federal agencies with programmatic responsibility for dealing with the aged. Consequently, many approaches, both formal and informal, have been established for coordination and joint program development. Among the many specific examples of collaborative projects, two are especially notable. First, in the area of senile dementia, the NIMH Aging Center, in collaboration with two NIH Institutes (National Institute on Aging and National Institute of Neurological and Communicative Disorders and Stroke), sponsored two international conferences on Alzheimer's Disease/senile dementia. These conferences, the first ever held, helped establish clarity and direction in the area. Second, with respect to service delivery, a regional training conference cosponsored by the Administration on Aging and the NIMH was held as the first formal step toward local-level collaboration of aging and mental health services. This approach will be repeated two more times in fiscal year 1980, to broaden service delivery coverage in the Nation.

Since 1974, staff of the NIMH Center for Studies of the Mental Health of the Aging have served on the Ad Hoc Interagency Committee on Research on Aging. This Committee, chaired by the Director, National Institute on Aging (NIA), and in conjunction with the National Advisory Council on Aging, helped define the research goals of the NIA, and now meets regularly for purposes of coordination and consultation. In addition, staff of the Center together with NIA staff also serve on the Interdepartment Committee on Aging conducted under

the auspices of the AOA, which is advisory to the Commissioner on Aging.

Although there exists a number of cooperative activities between the NIMH Center for Studies of the Mental Health of the Aging and the National Institute on Aging, there are two examples that I wish to bring to the attention of the Committee. Research applications of interest to both organizations are dually assigned. On occasion, projects with dual assignments, approved by the primary Institute, but for which sufficient funds are not available, have been transferred to the secondary Institute for funding consideration.

NIMH, in conjunction with the Bureau of Community Health Services, has provided funds and established over 100 linkages between federally assisted primary health care centers, CMHC's, and other mental health facilities. Since the elderly comprise a significant portion of the population in health centers they can be aided on the premises by our joint initiative to station a mental health worker in a community health center to provide consultation to physicians and nurses, evaluate patients, and make referrals to a local CMHC whether for drug, alcohol, or mental health problems.

CONCLUSION

It is of vital importance that we, in the executive branch, coordinate our activities and programs to maximize Federal dollars, eliminate waste and duplication, and provide the public with the quality of purpose and services that are needed during this period of prudent spending. We have established these goals with respect to our activities on the elderly. We have a measure of accomplishment that I have focused on in my testimony. I look forward to the continued direction and exchange that we have received from the Committee. This concludes my formal statement.

Senator PRYOR. Bob Benedict, Commissioner of the Administration on Aging, is here. Commissioner Benedict, we hope that you will give us a brief statement and then I may have a question or two and then we are going to have questions from the panel after we finish with Dr. Ewalt.

STATEMENT OF ROBERT C. BENEDICT, WASHINGTON, D.C., COMMISSIONER, ADMINISTRATION ON AGING, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. BENEDICT. I would like to submit a prepared statement for the record, Senator Pryor.

Senator PRYOR. Without objection, so ordered.[1]

Mr. BENEDICT. First of all, I think it is important for us to understand, as you and your colleagues have aptly expressed, that one cannot readily separate the problems of the mental illness of the aged from their problems of income, their problems of health generally, and their need for services.

Second: You have clearly identified some factors with regard to the scale of the problem. We estimate there are 4 to 5 million older people with serious physical and mental health problems. As one watches the demographics, that group is expanding by about 100,000 people a year. Unless the demographics change significantly, we can expect that expansion to continue for about one-half a century. So, while some advances are being made in specific areas, we still have to ask ourselves why the train is moving down the track faster than we are responding.

Third: I would like to note briefly some efforts that the Administration on Aging is making in this regard. In our training and educational program in higher education, we have funded 13 universities

[1] See page 89.

whose proposals and whose work include efforts in the area of mental health and aging. The applications we are receiving have an increasing focus in some of these areas.

In addition, as you know, the Administration on Aging and the Health Care Financing Administration are about to launch a series of community demonstrations in long-term care. These demonstrations will represent an effective joining of a wide range of current service providers, institutional and noninstitutional, to allow existing Federal resources to be used more effectively at the local level. The different modes of extended care these demonstrations are going to examine will give considerable attention to the mental health needs of the elderly.

Finally, I would like to note that this year the Administration on Aging has made an award to some 22 universities to estabish long-term care gerontology centers. This effort represents a joining of medical schools, schools of social welfare, and schools of public administration, to begin efforts to reshape the focus of training, research, and service in long-term care with a focus on interdisciplinary efforts. Each of these centers is to become fully operational over the next 2 years. The centers will have a particular focus on continuing education and community service.

Senator PRYOR. I will ask Commissioner Benedict on that point, what emphasis has been placed in those grants and in that interaction between the colleges and universities with regard to mental health in the elderly? You talk about the elderly but what relationship is there between the mental health aspects of the older population and——

Mr. BENEDICT. As these centers begin to develop their operational programs, we have clearly indicated to them that the inclusion of schools of psychiatry and mental health is important. When we launched the planning efforts for these centers, we received applications from universities which included over 40 percent of the medical schools in the country. This represents a real willingness on the part of medical schools to begin to join with these professional schools in focusing on chronic impairment, and the need for multidisciplinary efforts. So the interest is there, the concern is there, the problem is finding imaginative ways for Federal agencies to join their resources in the area of training and education, to shift their emphasis somewhat.

With those things in mind, I have one final observation. I think that the committee is right to convene the hearings, recognizing the importance of the issues of mental health and health discrimination as you have. They are not separate; it is a complicated problem and one that is going to tax the energies of the Congress and the administration considerably over the next decade, given the demographics that we have.

Senator PRYOR. Mr. Benedict, what types of provisions should I, as a Senator, or should we, as Members of Congress, be considering for the further involvement of the area agencies on aging out there in this country which serve the elderly and what should we try to bring about to see that their mental health needs are going to be met under the act? Don't write me a book on this now, just give me a general guideline here.

Mr. BENEDICT. I would suggest that the central issue is how better to join a broad range of services to achieve a sharper focus on the problems of those who are chronically impaired. If we could find ways to give communities the resources that they need to develop more substantial service delivery mechanisms——

Senator PRYOR. Do you feel the Administration on Aging today is putting the proper emphasis on mental health and the elderly in America?

Mr. BENEDICT. We have made some effort. I would not want to——

Senator PRYOR. No, I am not talking about making some efforts. I want to know, are you putting the proper emphasis?

Mr. BENEDICT. I don't know that I can answer the question as satisfactorily as you would like. We have consistently encouraged State and local agencies to work with the mental health community. We have encouraged agencies at the community level to increase their concern for the problems of older people who need care at home, and for the problems of older individuals who need protected living arrangements. These efforts certainly benefit the elderly who are mentally impaired. Are the services available through area agencies sufficient to meet basic community needs of older people with mental problems? The answer, unfortunately, is no.

Senator PRYOR. We will come back to you in just a moment, Commissioner Benedict. Without objection, your prepared statement will be entered into the record at this point.

[The prepared statement of Commissioner Benedict follows:]

PREPARED STATEMENT OF ROBERT C. BENEDICT

I. INTRODUCTION

Mr. Chairman, and other Members of the Senate Special Committee on Aging. I am pleased to respond to your invitation to testify on mental health and the aging, particularly as this subject relates to the activities and concerns of the Administration on Aging (AoA). The promotion of mental health among the elderly is a serious concern and a major challenge to the field of aging.

As you know, Mr. Chairman, many older persons live in situations and circumstances in which it is difficult to maintain healthy mental or emotional states.

—As individuals age, they often experience a series of losses—loss of vocational role, loss of spouse, loss of friends, loss of physical capacities. These losses can have a devastating impact on the individual. Moreover, as losses multiply, older persons have fewer of the supports, e.g., families, job, on which younger age groups can draw in meeting life's challenges.

—Isolation leaves many elderly without informal supports. 33 percent of the noninstitutionalized elderly live alone. 20 percent of the elderly (65-plus) have no living children. Family migration often leaves the elderly isolated. Only 33 percent of the elderly have children living within 10 minutes of them.

The difficulties which older persons sometimes face in maintaining mental and emotional health were clearly recognized in the panel report on the elderly submitted to the President's Commission on Mental Health (PCMH). The report discussed with considerable insight both specific mental health problems which the elderly confronts as well as the lack of attention which older persons often have traditionally received from providers of mental health services. (This latter point has also been underscored by the Civil Rights Commission's report on discrimination against older persons in federally funded programs.)

The services and programs authorized by the Older Americans Act can be of material assistance in helping older persons avoid and/or overcome mental health problems.

In my remarks this morning I will briefly survey:

—The opportunities which Older Americans Act programs offer to help the aged remain actively involved in their communities, thus avoiding isolation and feelings of uselessness.

—The services which the act helps pr. ide that relate to the needs of older persons with mental health problems.

—The activities we have undertaken with other agencies to increase and improve mental health services to our older population.

—The application of our discretionary resources to understanding the mental health needs of older persons and to fostering improved services.

II. THE OLDER AMERICANS ACT: OPPORTUNITIES FOR COMMUNITY INVOLVEMENT

We all want "(T)he best possible physical and mental health which science can make available without regard to economic status" for older Americans. The programs of the Older Americans Act contribute to the achievement of this objective by providing the elderly with opportunities to remain actively involved in their communities. Such involvement is widely recognized as a means of preventing or forestalling physical and mental deterioration.

Older people are the first to recognize the many benefits that accrue from community participation. Their record of involvement is truly impressive:

—More than 13 percent remain in the work force.

—More than 20 percent are actively engaged in community volunteer activity.

—Cultural and family life are central to their lifestyles. Nearly 80 percent regularly attend a church or synogogue.

—Older people are more active politically than their younger counterparts. They vote in substantially greater percentages than younger people. In 1978, 56 percent of eligible voters over 65 cast ballots as opposed to 45.9 percent of all eligible voters.

More opportunities are needed, however, for involvement by the elderly. Although not primarily designed as employment or volunteers programs, the activities authorized under title III of the Older Americans Act offer older persons opportunities for both paid employment and volunteer participation, as the following fiscal year 1979 data indicate:

—Persons 60-plus constituted 10 percent of the paid staff of the State agencies on aging.

—Those 60 and over comprised 30 percent of the staff employed by area agencies on aging.

—In the nutrition program, 35 percent of the paid staff were older persons.

—Older volunteers provide invaluable assistance to area agencies and nutrition sites. In 1979 they constitute more than 80 percent of the volunteers active in these programs.

In addition, AoA cooperates with, and supports, the efforts of the Labor Department in providing employment opportunities for older people, as authorized by title V of the Act. As you know, more than 50,000 older workers are currently employed under the title V program.

The cooperative agreement which AoA has undertaken with the American Personnel and Guidance Association is also designed to help foster involvement for older persons. This program will strengthen the capacity of service providers to assist the elderly through improved counseling and referral. As a result, older persons can become more aware of opportunities for employment, volunteer work, and training, and more knowledgeable about how to exploit these opportunities.

III. THE OLDER AMERICANS ACT: SERVICES TO ADDRESS MENTAL HEALTH NEEDS

The Older Americans Act thus makes possible a number of opportunities for involvement and community participation. For older individuals, who are afflicted with mental health problems, the service systems which are supported through title III resources can help significantly. In-home services, counseling, day care, respite services, access services, protective services, and case management services are all directly relevant to the needs of vulnerable older persons. Information and referral services provided under the act help to steer older persons who need mental health services to community mental health centers and other mental health assistance.

In this same context I would also like to mention the system of advocacy assistance which AoA established several years ago with our discretionary grant resources. This system was cited by the HEW task force on the PCMH report

as a useful model for implementing "advocacy systems for the representation of mentally disabled persons." These systems were recommended in vol. I (p. 42) of the PCMH report. In addition to their potential role as guides for models, our advocacy assistance efforts are, already helping older persons with mental health problems to obtain their basic rights and entitlements.

IV. INTERAGENCY ACTIVITIES

AoA recognizes that our efforts alone are not sufficient to conduct all the activities and provide all the services needed to address the mental health needs of older people. Accordingly, we have sought to draw on the resources of other agencies in efforts to devise effective strategies in the mental health area. We have developed an interagency agreement with the National Institute of Mental Health designed to encourage cooperation at the Federal level between NIMH and AoA. The agreement also promotes maximum cooperation between and among State and local agencies which implement AoA and NIMH programs. AoA and NIMH, based on the interagency agreement and our respective memoranda of understanding with the Federal Emergency Management Agency, have worked closely in providing mental health services to older disaster victims in Presidentially declared disasters. Some examples: Johnstown flood, Rochester (Minn.) flood, Appalachian floods.

Another example of the cooperation which has occurred between the aging and mental health networks is the Pilot Training Conference which was jointly undertaken by AoA and NIMH.

The Conference, conducted November 27–29, 1978, gathered Federal, State, and local program staff members from DHEW regions I, II, III, and IV (the regions on the eastern seaboard) to discuss problems in the delivery of mental health care to the elderly and to formulate and exchange approaches and solutions to these problems.

One of the issues which emerged from the 1978 meeting pertained to the types of services, e.g., outreach, counseling and therapy, residential (in-home) care, medical care (both in and outpatient), employment, social services, etc., most relevant to older persons with mental health needs. Representatives of both the AoA and NIMH networks agreed to increase their efforts at the community level to identify the mixture of services most relevant to individual situations.

The success of the initial Conference venture has indicated a need to conduct similar Conferences in the Midwest and Western regions and these are now being planned.

AoA will continue its efforts to strengthen the system of services to the elderly through the kinds of activities described above.

In addition, we are investing discretionary grants resources in a number of projects designed to assist older persons to avoid and/or to overcome mental health difficulties.

V. RESEARCH AND MODEL PROJECTS

During fiscal years 1980–82, AoA will complete projects, representing a total of $1,325,200, which focus on mental health needs of older persons. The following are examples of projects now underway:

—The University of Miami (Florida) Department of Psychiatry has a 3-year grant (through September 30, 1980), to develop and demonstrate the effectiveness of innovative mental health counseling and community services for prevention and early intervention for Hispanic elders in the Dade County, Fla., area.

—The Portland State (Oregon) University Institute on Aging has an 18-month grant through September 30, 1981, to determine how community intervention programs can be designed to most effectively serve the elderly person experiencing a pivotal life event (which can adversely affect mental health).

—AoA is in the final stages of negotiating a grant to study and report on the extent to which activities of the aging network have included the promotion or provision of mental health services for older persons. Data will be obtained from State units on aging and area agencies on aging on the extent to which they interact with mental health providers to influence the delivery of services to the elderly.

—A county mental health center in Northhampton, Mass., has a 2-year model project grant, through February 28, 1981, to strengthen the informal support systems of noninstitutionalized rural older persons, including family, peers, and natural helpers. This project is designed to develop valuable findings, among others, concerning the efficacy of informal support systems

in maintaining good mental health in old age and avoiding the necessity of placing older persons in mental institutions.

—The Mental Health-Mental Retardation Board, Inc., of Covington, Ky., has a 3-year model project grant to test a program of avoiding institutionalization, with particular attention to maintenance of mental health, by providing a therapeutic day environment with social reinforcement activities.

VI. LONG-TERM CARE

Various provisions of the 1978 amendments of the Older Americans Act call for increased emphasis upon wise and efficient use of the Nation's long-term care facilities, and upon prevention of unnecessary institutionalization of the elderly. To implement these provisions, I have established a Long-Term Care Unit within AoA to be the focal point for using discretionary funds in the development of more effective long-term care policies and programs. The activities of this unit should result in improvements in care of the vulnerable elderly, including those vulnerable to mental health difficulties. The unit will be responsible for a number of activities which support our efforts to address mental health needs among older people, including the long-term care channeling demonstrations, our new program of geriatric fellowships and the long-term care policy centers.

Long-term care channeling demonstrations

A major programmatic activity of the Long-Term Care Unit is responsibility for AoA's share in the long-term care channeling demonstration projects which are being conducted under a joint initiative between AoA and the Health Care Financing Administration. These projects will seek to: (1) Determine the extent to which State and local community agencies can improve the match between client need and services received without requiring a significant amount of new dollars; (2) limit unnecessary utilization of acute care and nursing home facilities; and (3) maximize the use of in-home and community services in a manner that is economically feasible and does not unnecessarily substitute for the informal care rendered by family and friends. Needless to say, these projects should help point the way to prevent unnecessary institutionalization of the elderly who need mental health services, and assuring them in other ways of appropriate levels of care.

Geriatric fellowships

The Geriatric Fellowship Program is an effort to improve the quality of medical care and to encourage new professionals to enter the field of geriatric medicine. The Administration on Aging is supporting a selected number of geriatric fellowships which will offer future medical professionals experience with the special body of knowledge related to geriatric medicine, the special ethical issues related to the care of older persons, the social, economic, and psychological problems which interact with health problems, and new approaches to long-term care in the community and/or institution.

Long-term care policy centers

In fiscal year 1979 AoA launched a new program of support for "gerontology centers of special emphasis." Supported with resources authorized under title IV, part E (Multidisciplinary Centers of Gerontology) these new centers will be a focal point for carrying out integrated programs of multidisciplinary training and practice, basic and applied research, and technical assistance. Each center, when fully established, should contain a complex of professional and academic components appropriate to its special subject area.

Top priority has been given to establishment and development of long-term care gerontology centers which focus on health and social service systems for the chronically ill and disabled elderly. Twenty-two awards were made in fiscal year 1979 to support the planning and development of such centers. In fiscal year 1980 there will be additional funding for full-scale operational long-term care gerontological centers.

VII. CONCLUDING COMMENTS

Mr. Chairman, this completes my prepared remarks. I will be happy to answer any questions which you or the other committee members may have.

Senator PRYOR. Dr. Ewalt, I want you to know that recently I had the privilege of touring the Veterans' Administration Hospital in

Arkansas. It was, I guess, 10 years ago when I did that the last time and I was very pleased to see the progress. I was also very pleased to see that we are doing a great deal there in the area of geriatrics for our veterans or we are beginning to, I should say. We have been sort of negligent about that whole field in the last several years but I think the veterans certainly have a particular concern and a particular problem, it seems like, and particular sensitivities and vulnerabilities I should say. You certainly have been an advocate in this area and we would like, if you would care to, for you to make a statement or put it in the record and submit yourself for questions.

STATEMENT OF JACK R. EWALT, M.D., WASHINGTON, D.C., DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION

Dr. Ewalt. I will present a very brief statement and present details for the record, if I may.

Senator Pryor. Yes; your written statement will be made part of the record.[1]

Dr. Ewalt. I think I can bear personal testimony to an interest in aging. Four years ago I retired as chairman and one of the deans of a well-known medical school. I was retired because of my advanced age. [Laughter.] I am old enough, 70.

We have 30 million veterans and they are all getting older. I pray to God we don't have another war and this proportion will go up. At the end of the last fiscal year, 2.8 million of the 30 million were over 65. This is about 9 percent. Our projections show that by the year 2000 we will have 29 percent of our veterans over age 65 and that will be about just under 8 million. It is very important for us because the utilization of veterans hospitals and other medical facilities goes up if you are poor, it goes up if you are old, and it goes up if you have a long-term illness.

All of these, of course, are patients who tend to be in the psychiatric category. To try to cope with this we have a number of innovative programs underway at the Little Rock hospital; one of eight centers where we have geriatric research and education centers to do research in geriatrics and to educate staff at all levels of care for geriatric patients. In addition, we have initiated 12 geriatric fellowships where our physicians can take 1 year on full salary and specialize in geriatrics. According to Dr. Weinberg's statement, experience is fine but you need education if you are going to do a good job. We believe this program is going to expand, as it is a rather new one.

We also have a number of research projects that are relevant to geriatrics; in metabolic disease, cardiovascular disease, cancer, schizophrenia, and alcoholism. So I think the veterans are very much interested in aging out of humanity and our responsibility is to take care of the veterans and if they are getting older we are going to be more and more into the geriatric business.

Senator Pryor. We have gone through a long period in this country where we have not emphasized geriatrics as it relates to the veterans' population. Would this not be correct?

---

[1] See next page.

Dr. EWALT. I think this is true. We are certainly into it up to our ears now in terms of interest in it and the number of patients. For example, we have what is called extended hospital care. These are persons with long-term illnesses like diabetes, cancer, and heart disease. There are over 10,000 patients in that program countrywide and over 51 percent of them are over age 65.

Senator PRYOR. Is there an adequate amount of sharing between all of the various agencies and departments of Government of coordination of information and data that has been gathered so that you might have the benefit of their data and they might have the benefit of your data?

Dr. EWALT. Well, we do share data with the patient turnover. We get their data. I have those two books you mentioned. Also within the agency we have over 8,000 contract nursing home beds, and other examples of this sort. We work with the community mental health centers quite often, particularly in the area of alcoholism. Many of the alcoholics are people of advanced age.

Senator PRYOR. You don't sense that there are any bureaucratic turf battles out there, do you?

Dr. EWALT. I am not aware of any.

Senator PRYOR. If you find any, let me know; I want to eradicate them because it is senseless for us to be committed to such a course and find that we are not getting cooperation from the bureaucracies that we should. Please don't hesitate to let us know as a committee.

Dr. EWALT. I appreciate that and I certainly will. Our orientation is a little different in that we are not dependent on insurance plans. Due to the beneficence of Congress, medicare, and medicaid, and insurance we do not have to worry about them. If a veteran is indigent or service-connected, we pay the bill to these contract homes and similar facilities. We don't have to go through the authorization routine. We have really had, so far as I am aware, very little problem in cooperating. There are many, many committees for interagency cooperation.

Senator PRYOR. Dr. Ewalt, thank you very much. Your prepared statement will be entered into the record at this time.

[The prepared statement of Dr. Ewalt follows:]

PREPARED STATEMENT OF DR. JACK R. EWALT

Mr. Chairman, I am pleased to appear before this committee today to address the Veterans' Administration's role as a major provider of health care in the areas of aging and mental health. In light of the increasing average age of the nearly 30.1 million American veterans, the VA is keenly aware of the health care problems and needs of an aging population. A focus on the mental health of the aging veteran is an important facet of our health care program. Today, I would like to speak briefly to these issues and then make myself available for the questions that you or the committee may have.

As you know, the Veterans' Administration operates a large, sophisticated health care system with approximately 85,000 hospital, 8,400 nursing home care, and 9,300 domiciliary beds. Currently, we contract for approximately 8,500 community nursing home beds and contribute per diem toward the operation of approximately 5,400 State home nursing home care, 1,000 State home hospital, and 8,700 State home domiciliary beds. On September 30, 1979, 2.8 million veterans or 9.2 percent of the total veteran population were 65 years or older. Current projections show that the number of veterans 65 years and older will peak in 1995 at 8.2 million and this will represent 28.7 percent of the veteran population. In 2000, the percentage of aging veterans continues to increase to 29.1 but the total number shows a slight drop to 7.9 million.

This aging trend is very important in planning for health care. Experience shows that in the age bracket 20 to 24 years 27.9 of each 1,000 veterans will report to some VA medical center for care. In the 65-year-and-over bracket, utilization rises to 33 per 1,000 in any year. Data also shows that as patients who are older, poorer, and with illnesses requiring longer periods of care, such as cases suffering from some form of cancer and cases suffering from some type of psychiatric disorder, tend to more frequently use VA medical center care rather than community facilities. In terms of collaboration with private sectors the following data are of interest. Those veterans with incomes under $4,000 per year utilize our health care services at the rate of 65 per 1,000, while the rate among veterans with incomes of $10,000 or more per year is only 5 per 1,000 (the factor of age enters into this as well). For the age span 20 to 54 years the VA offers medical care to about 10 percent of all veterans hospitalized in all facilities in the United States. For those over 55 years of age, the VA market share rises to 15 percent. Another way of looking at this use figure is that of all veterans hospitalized on a day about 1 in 10 to 1 in 15 are in a VA hospital, but of those treated for disorders such as mental illnesses or malignant neoplasms requiring more days of care, the utilization rate of VA hospitals by veterans is 1 in 5 of those treated on any day.

The Veterans' Administration facilities for the care of older veterans are principally in the extended care service, the medical service and the psychiatry service. Many of the patients in the intermediate medical care and in the extended care facilities have a psychiatric diagnosis as well as that of some physical disability. On a given day the medical service in extended hospital care has about 10,500 patients (about 50 percent of these also contain a psychiatric diagnosis). Of this group 51 percent are 65 years or over and it should also be noted that some of the extended care services report increasing numbers of admissions for long-term medical care directly from the community and not as transfers from one of the VA medical center wards or clinics.

Of the patients with a psychiatric diagnosis who are age 65 years and older, 76 percent are on a psychiatric ward and 24 percent are on other wards, principally medicine. Many other psychiatric patients are in VA and community nursing home facilities, VA domiciliaries, and community care homes. The number of aged veterans cared for in nursing homes and domiciliaries will increase. We project that the percentage of veterans 65 years and older who are in extended care facilities will increase from 67.1 to 80.5 percent for VA nursing homes and 36.4 to 63.6 percent in VA domiciliaries. Similar increases of from 10 to 17 percent increases are expected for community nursing homes as well as State home nursing homes and domiciliaries. With these data and trends in mind, the VA has developed plans to meet these increases in the demand for care by aging veterans.

Among the Veterans' Administration's innovative programs in the area of aging are the eight geriatric research, education, and clinical centers (GRECC's). These GRECC's are located at the Bedford, Mass.; St. Louis, Mo.; Seattle, Wash.; Palo Alto, Calif.; Los Angeles (Wadsworth), Calif.; Sepulveda, Calif.; Minneapolis, Minn.; and Little Rock, Ark., VA medical centers. The benefits of the research and education performed by these centers extend beyond the care they provided. The GRECC's are seen as making a significant contribution to the field of aging research, and they also represent a major mechanism for attracting new professionals into the field of geriatrics and gerontology.

In addition, the Veterans' Administration supports, through its research program, research on problems in long-term psychiatric disease such as senile dementia and alcoholism, as well as a variety of cardiovascular, neoplastic, and metabolic diseases common among aging individuals.

The Department of Medicine and Surgery has sponsored psychogeriatric programs at the VA Medical Centers in North Little Rock, Lyons, Northport, and Salisbury. Many others have units specializing in psychogeriatrics. A large number of aging patients are in various types of community-based care. It is believed that some of these patients will make a better adjustment in the community and many show some improvement in their physical and mental state if kept physically and mentally active. To serve some of these patients, the Department of Medicine and Surgery operates geriatric day care programs at VA Medical Centers in Palo Alto, North Chicago, Boston (Outpatient Clinic), and Loma Linda. We anticipate that this number will increase as staff and support become available. The Veterans' Administration has established geriatric fellowship programs with 12 VA medical centers which are affiliated with medical

schools. These fellowships will develop expertise of the VA physician—fellows in the care of older patients. It is expected that these fellowships will augment the VA's capacity to care for older patients but because of our affiliation with medical schools, and the participation of VA physicians in teaching and training of residents and students as part of the clinical care of our patients, the influence of these fellowships will extend into the general population and will therefore have an impact beyond the VA.

The present geriatric fellowships are at the VA Medical Centers in Bedford, Durham, Gainesville, Lexington, Little Rock, Los Angeles (Wadsworth), Madison, Palo Alto, Philadelphia, Portland, and the VA Medical Center Sepulveda, Calif. The Department of Medicine and Surgery has conducted training programs for chiefs of service in psychiatry and psychology as part of an administrative program to keep service chiefs abreast of modern trends and modern needs. The VA's seven regional medical education centers (RMEC's) offer courses in gerontology. Attendees of the courses are expected to return to their medical centers and by supervision, seminars and example, augment the quality of care for our aging veteran patients.

In summary, the Veterans' Administration Department of Medicine and Surgery has an extensive program directed to the care and rehabilitation of our aging veteran population.

Senator PRYOR. I understand at 11 o'clock we are probably going to have a vote and I will probably at that time leave for about 10 minutes. I am going to try to do something if I could. I am going to try to start moving down this panel very quickly. If you would like to comment on anything that has been said, feel free to do so. If you would like to ask unanimous consent to have your full statement placed in the record, feel free to do so. Otherwise, just give us a few thoughts and let us complete the entirety of this panel before we open it up for an interchange between both sides of the room.

Bill Hutton here is a great advocate for the elderly. I worked with Mr. Hutton on many occasions. I will try to maybe just ask one or two questions from time to time of these panelist.

Bill, if you would proceed and go very quickly. We will go down this side to the end and then we will ask for questions to begin our interchange.

STATEMENT OF WILLIAM R. HUTTON, WASHINGTON, D.C., EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HUTTON. Mr. Chairman, with your permission then, I will just really highlight some of the prepared statement and you can put the statement in the record.

Senator PRYOR. Your statement will be entered into the record.[1]

Mr. HUTTON. I would like to make a couple of comments. First, it must be very clear to anybody who is looking for improvement that the mental health needs of the elderly have been long ignored, not only by Government agencies, medical practitioners, social welfare applicants, legislators, but even by groups representing the elderly. This kind of inaction has had a very, very serious effect, even though hope was expressed by one of the panelists on the other side that we perhaps are reaching that historic turning point in the treatment of mental health, and he gave us something which gave him that hope.

It really does not sound very good to me. I don't like the thought, for example, that we must mention that terrible word "money" and "funds" in all this. We are not going to be able to do a thing without money and funds; this country must get down to the basic, the nitty-

[1] See page 98.

gritty, that all change which is beneficial to people is going to cost money, and the sooner we accept that the better.

One of the areas which perhaps might point to that turning point is, of course, the evidence of Claude Pepper. I remember he sponsored that National Conference on Mental Health and the Elderly. And then the efforts of Mrs. Rosalynn Carter, who has given the strong impetus to the President's Commission on Mental Health. These were two things, but I am really very encouraged by this committee taking an interest.

If I may just be personal for a moment, because I know that you are spearheading it and I know you, I worked with you. I remember a decade ago how, when we turned our attention to the plight of the people who were in the Nation's nursing homes, we got an awful lot of publicity on turning the searchlight on what was going on in the Nation's nursing homes, but we didn't achieve very much; some changes perhaps, but in actual fact, I think the net result was that the American Nursing Home Association, which got to look at the words "nursing home" as a dirty word, changed their title to the American Health Care Association. The one thing they don't provide is health.

Be that as it may, you started out this morning by saying that we have to look to the positive side, and it is on that positive side I would like to dwell just for one moment or so. I would like to refer to the statistics which you reported in the opening statement that you made. There are a couple more that I think should be stressed, as I see it.

Sixty percent of nursing home patients suffer from some form of mental anxiety, yet very, very few of the Nation's nursing homes provide mental health care. Up to 65 percent of older people demonstrates some degree of depression, and yet this is a condition responsive to therapy when conducted by an appropriate mental health professional.

I said that despite these tragic facts, mentally ill older Americans are not receiving the benefits of mental health care services available to them. The elderly are grossly underrepresented in all kinds of treatment programs and it is clear that if we do nothing else in this attempt to turn the Nation around, we must take steps to improve the delivery of mental health services to the elderly, and improving that delivery to all of them is very, very important.

We believe that these remedies that we are looking for have got to include the linking of primary health care to mental health care services and fostering home health care services in every possible way that we can. We also have got to increase the awareness and the sensitivity of mental health care personnel.

I was glad to hear Dr. Weinberg talk in that area. I know about doctors and training of doctors, but the fact is that the prejudices against providing mental health care for senior citizens, that we described earlier this morning, particularly with regard to primary care physicians, are also harbored by mental health personnel, because they are generally not trained in the particular needs of the elderly. There has to be a more concentrated effort at in-service staff training on the subject.

Mental health care personnel have got to be taught to appreciate the many stresses in the lives of the elderly, such as retirement and the death of a spouse. All of these things can bring about mental illness. It is not just the doctors that need to be taught, it is the staffs. In fact,

most of the real heartache in our nursing homes is not really caused by the doctors; as a matter of fact, they don't even go there often enough to cause the heartache. The heartache in the treatment is caused by untrained staff who push the patients around, who tie them up, who don't understand what is going on.

Our paper describes at least five steps, and I suppose that while they are all readily available, perhaps the most important you have already begun—advocacy. Quality mental health care services of a sufficient quality to meet the needs of communities can develop only if there is an ongoing assessment and advocacy of these needs, and it is not being done outside of very, very wonderful statements from time to time.

The fact is that we are not really talking about it on a regular permanent basis and assessing what we have done. Literally millions of older people out there are either suffering now or are potential sufferers, and I can tell you that there is not a member of the Office of Management and Budget who seems to care a damn. It is time that this country recognized that many of those people can be brought back. Many of them can recover if they have a chance to get the treatment. If we don't, then we are just letting people die, and I think it is a very tragic situation.

Senator PRYOR. Bill, in a moment may I ask you some of your specific recommendations. Your prepared statement will be entered into the record at this point.

[The prepared statement of Mr. Hutton follows:]

PREPARED STATEMENT OF WILLIAM R. HUTTON

Mr. Chairman, members of the committee, I am William R. Hutton, executive director of the National Council of Senior Citizens. The National Council is a nonprofit, nonpartisan organization composed of 3,800 local clubs and State and area councils across the country. We have testified on innumerable occasions on proposals to provide adequate health care for all Americans. We are pleased to be here today to present our views and suggestions on the improvement of mental health services for the elderly.

The mental health needs of the elderly is an area which has long been ignored by Government agencies, medical practitioners, social welfare advocates, legislators, and even groups representing senior citizens. This inaction has had a particularly devastating effect on the hundreds of thousands of elderly victims of mental illness whose anguish remains unrelieved due to the unavailability of adequate mental health services. We can ignore the problem no longer—it's too pervasive, too severe. Thanks to the efforts of Representative Claude Pepper, who sponsored the National Conference on Mental Health and the Elderly, and Mrs. Rosalynn Carter, who has given strong impetus to the President's Commission on Mental Health, the issue has been brought out of the closet and much-needed reforms have been proposed.

Briefly, some of the symptoms of this problem are as follows:

Between 18–25 percent of all senior citizens suffer from significant mental illness.

Twenty-five percent of all suicides are committed by elderly people.

Up to 65 percent of older people demonstrate some degree of depression—a condition responsive to therapy when conducted by an appropriate mental health professional.

Studies show that the chance of developing psychosis increases after age 65; even more so after age 75, which is the fastest-growing segment of our society.

Three million senior citizens suffer from dementia, a condition which is now treatable in up to 20 percent of victims. Two-thirds of these mentally ill persons live within the community.

Sixty percent of nursing home patients suffer from some form of mental illness; yet very, very few nursing homes provide mental health care.

Despite these tragic facts, mentally ill older Americans are not receiving the benefits of mental health care services available to them. The elderly are grossly underrepresented in various treatment programs: Although they now represent 10.9 percent of the general population, studies show that only 4 percent of patients at community mental health centers are senior citizens and fewer than 2 percent of private psychiatrists' patients are elderly. Clearly, steps must be taken to improve the delivery of mental health services to the elderly. The National Council of Senior Citizens believes that these remedies must include linking primary health care to mental health care services; fostering home health care services; increasing the awareness and sensitivity of mental health care personnel to the needs of the elderly; increasing linkages among existing community support services; and, developing a system of advocacy for the mental health needs of senior citizens.

Before discussing these recommendations in greater depth, we should note that an improved system of reimbursing the costs of mental health services under medicare and medicaid is vital to increasing the availability of such services to the elderly. However, the discussion of this issue has already begun in the Congress and in the administration and we have testified on the subject of medicare and medicaid reform before the Health Subcommittee of the House Ways and Means Committee. Therefore, our focus today is on improving the delivery of mental health services for older Americans.

It is well known that physical and mental health problems are often closely related. It is apparent, therefore, that mentally ill, elderly individuals would benefit greatly from increased sensitivity and cooperation between primary care and mental health care providers. Unfortunately, the U.S. Commission on Civil Rights reported in January 1979 that consultation and education efforts by community mental health centers directed toward providers of services for the elderly occupied only 5 percent of staff hours. The need for such linkages is underscored by the existence of certain misconceptions among physicians and hospitals regarding the treatment of mental illness for the elderly. Contrary to common belief, these illnesses are very often responsive to treatment—mental illness is not just a symptom of old age. There is also a tendency to make mental health care for the elderly a low priority because "the old will die soon anyway." This impersonal, cost-benefit analysis cannot be tolerated. We believe that community mental health care providers must be required to increase their efforts at educating and establishing linkages with primary care physicians regarding the benefits of mental health care for the elderly. In this regard, we are pleased to note that S. 1177, the Mental Health Systems Act as amended by the Senate Committee on Human Resources, would require followup and tracking of patients discharged from institutional care facilities and provide for individual case management services. The bill also makes a great stride in requiring that multioccupancy, residential facilities (such as boarding and nursing homes) insure the availability of mental health services for their residents in the community.

Our second proposal is to increase the availability and utilization of home health care services for mentally ill, elderly individuals. It is generally recognized that the home setting, where appropriate, increases the effectiveness of treatment by allowing the individual to remain in familiar surroundings. Currently, the largest obstacle to full use of home health care and homemaker services is the reimbursement program under medicare and medicaid. It is encouraging to note that the proposed Mental Health Services Act is supportive of care provided in noninstitutional residential and least restrictive settings and would authorize a study of the effectiveness and cost of health services provided at home. Hopefully, we will soon see the day when home-care and support services are a central part of the mandate to community mental health centers.

The prejudices against providing mental health care for senior citizens, that were described earlier regarding primary care physicians, are also harbored by mental health care personnel. Because the staffs of mental health centers are not generally trained in the particular needs of the elderly, there must be a concentrated effort at inservice staff training on this subject. Mental health care personnel must be taught to appreciate the many stresses in the lives of the elderly, such as retirement and death of spouse, that may bring about mental illness. They must also be educated regarding the nature of the elderly's mental health problems—that these conditions are often reversible and are not inevitable byproducts of the aging process.

Greater use of existing community support systems would also improve the delivery of mental health care services. To this end, we are pleased that the

proposed Mental Health Systems Act would require the States to develop comprehensive service plans, while emphasizing the need for local determination of which services are the most needed and which population groups are unserved or underserved. This is necessary because current law authorizing direct funding from Washington of community mental health centers failed to insure that various populations, such as the elderly, were receiving sufficient services. Many organizations, such as the area agencies on aging, will be extremely helpful in determining which services are available in the community and how different service providers can work together. We would stress, however, that the management and development of community mental health care systems should not become the responsibility of the area agencies on aging.

Our fifth recommendation concerns advocacy. Quality mental health care services of sufficient quality to meet the needs of the community can only develop if there is ongoing assessment and advocacy of these needs. Several States already have advocacy programs which protect the rights of patients of long-term care facilities and insure the quality of the services provided. Such a mechanism is sorely needed in the area of mental health care services, and we are glad to see that this concept has been incorporated into the Mental Health Systems Act.

We would like to make one final recommendation regarding funding for the community mental health services system. The U.S. Commission on Civil Rights reported in 1979 that in a climate of scarce resources, mental health services administrators had to assign a low priority to outreach and education activities. These activities are essential to the development of linkages needed for a comprehensive system of community mental health services. We, therefore, urge the fullest possible authorizations for the community mental health programs in conjunction with a firm mandate to devote a significant portion of these resources toward consultation and education.

Mr. Chairman, thank you again for this opportunity to express our concerns to you and to the members of the committee.

MEDICARE/MEDICAID REFORMS SUPPORTED BY NATIONAL COUNCIL OF SENIOR CITIZENS

Designate community mental health centers as qualified providers of mental health services.

Provide for reimbursement for up to 25 visits per year at a community mental health center and partial hospitalization by a center for up to 60 visits per year.

Eliminate the 190-day lifetime limit on full psychiatric hospitalization days.

Raise the annual benefit cap from $250 to $750.

Raise the Federal coinsurance rate for private psychiatrist services from 50 to 80 percent.

Senator PRYOR. Next, we have Dr. Paul Kerschner from the AARP. We are proud that you are here with us today. You have been a longtime advocate for the elderly and we appreciate your presence with us.

STATEMENT OF PAUL A. KERSCHNER, PH. D., WASHINGTON, D.C., ASSOCIATE DIRECTOR OF LEGISLATION, RESEARCH AND DEVELOPMENTAL SERVICES, NATIONAL RETIRED TEACHERS ASSOCIATION/AMERICAN ASSOCIATION OF RETIRED PERSONS

Dr. KERSCHNER. I did want to point out there has been a study done in Israel that shows the proportion of psychiatrists increases directly with the proportion of attorneys. Israel has the very highest proportion of attorneys. I don't know if that bodes well for the United States or not.

In addition to my prepared statement, I will submit for the record a larger statement from the NRTA/AARP.[1]

Senator PRYOR. Your prepared statement will be inserted into the record.[2]

[1] See appendix, item 2, page 146.
[2] See page 102.

Dr. KERSCHNER. I want to concentrate on something alluded to earlier, and that is what has happened over the last few years with the process of the deinstitutionalization of elderly from the State mental hospitals. What has happened is that the majority of those elderly who were taken out of State mental hospitals ended up in nursing homes or board and care facilities. To be fair to the nursing home industry, we are asking them to take care of a complex patient mix at a minimum cost. It is almost impossible to do when you have a patient mix of mentally ill, alcoholics, chronically ill, brain damage, and so forth. It cannot help but cause severe problems. If you add on the inability of the third party payers, such as medicare and others, to pay for mental health services, you can see the problems we are creating for ourselves.

The second issue is one that was alluded to earlier today, that is the lack of training provided to mental health staff, including psychiatrists. I don't think the Government, Senator, nor the private and public medical schools can offer enough incentives or enough carrots. I think the time has come for the aging groups in this country and their advocates to begin to push the society for better mental health services for older people, including a demand for well-trained physicians and accessible mental health centers. They will begin to respond when large numbers of older people demand quality services. I frankly think the aging groups, and the aged themselves, have been remiss in standing up and demanding that quality mental health services be delivered and that moneys be there present for them.

Third, and I mentioned this earlier when I was introduced, I think we are not making enough use of older people as service providers. Given the mood of Congress, the existence of legislation like prop 9 and prop 13, we are going to have to rely increasingly on older people to provide services to their peers. I know that at USC, University of Southern California, and other institutions, they have made very good use of peer counselors to deliver quality mental health counseling. Clients may then be referred to more skilled professionals when the need is there. I think those sorts of experiments should be increased.

Let me summarize by stating, in terms of legislation, where the associations stand. It is time that we realized medicare must begin to pay for more than bed care. Maggie Kuhn, a long-time colleague of mine, always says medicare sends people to bed, and it is not for sex and aging, but because that is the only place you can get things paid for. You cannot get services on the outside.

Second, we agree with you that we should provide partial hospitalization visits and authorize payments for psychologists and other mental health visits.

My last comment would be that I think the aging network, whether that be area agencies or State or membership groups or whatever, need to join forces with the National Institute of Mental Health, NIA, AoA, and begin to attack this problem. I don't think the answer is necessarily more legislation, for example. I think it is to hold our feet to the fire to see that we work with the existing agencies that already have the obligation to provide these services.

Thank you, sir.

Senator PRYOR. Thank you very much. You answered my two questions in your last moment or two there.

67-899 O - 80 - 4

Without objection, the prepared statement of Dr. Kerschner will be entered into the record.
[The prepared statement of Dr. Kerschner follows:]

PREPARED STATEMENT OF DR. PAUL A. KERSCHNER

Mr. Chairman, I am Dr. Paul Kerschner, associate director of the National Retired Teachers Association and the American Association of Retired Persons. Our associations are here today to offer testimony on a problem of increasing importance for our Nation's elderly, the need for appropriate and accessible mental health services. While many groups have a legitimate claim to such services, the magnitude of the mental health problems of the elderly clearly demand special attention.

The President's Commission on Mental Health, the Department of Health, Education, and Welfare's Task Panel on Mental Health of the Elderly, the House Select Committee on Aging and this committee have all documented the fact that the significant mental health needs of the elderly are not being met by existing service and reimbursement programs. Those over the age of 65 show the highest prevalence of mental disorders and the highest suicide rate. They occupy a full 29 percent of all public mental hospital beds. Moreover, 23 percent of our Nation's 1.3 million nursing home residents have as a primary diagnosis either a mental disorder or senility without psychosis. Yet the National Institute of Mental Health (NIMH) has indicated that approximately 80 percent of our elderly citizens who need assistance this year for emotional disturbances will not be served. Estimates are that only 2 percent of all patients in private psychiatric care and only 4 percent of all persons seen at public outpatient mental health clinics are over the age of 65. Furthermore, only 2 percent of all medicare funds go toward mental health services and merely 4.1 percent of the (fiscal year 1980) budget of NIMH has a major focus on aging.

Within this context, our associations find the recent trend of deinstitutionalization disturbing. Whereas over the past 30 years the number of mentally ill persons in State mental hospitals has decreased by two-thirds to 146,000, the number in nursing homes had trebled to over 300,000 so that today a full 50 percent of the chronically mentally ill are residents of nursing homes and board-and-care homes. Moving the elderly patient out of the hospital or nursing home and into the community is correct—but only when and where proper treatment and continuing case management services are available.

The fact that community-based programs have grossly underserved the elderly is a function of broad-based age discrimination practiced by mental health professionals and the stigma most older Americans attach to mental health services. Professionals, especially psychiatrists, receive little training in the treatment of elderly patients and display a general lack of sensitivity and awareness to their special mental health problems. In fact, due to the perverse medicare reimbursement system which discriminates against the mental patient and community-based services, it has been estimated that over 80 percent of the mental health services the elderly receive are from primary care or general practitioners—sometimes with disastrous results. Therefore, our associations continue to support the stepwise and cost-effective elimination of discriminatory treatment of outpatient services under medicare, conveying provider status to CMHC's, providing partial hospitalization visits and authorizing payment for services performed by a clinical psychologist. As such, we have endorsed Senator Heinz' bill S. 1289 (The Medicare Mental Illness Non-Discrimination Act) and recent improvements in medicare coverage for outpatient mental health services included in the 1980 Medicare Amendments (H.R. 3990). We would hope that the Senate would add these latter provisions when it considers H.R. 934 (Medicare and Medicaid Reimbursement Reform Amendments) on the floor in the near future.

Establishing linkages, coordinating the delivery of mental health services, aggressive outreach programs and reimbursement reform in our view is the foundation upon which to build an effective mental health delivery system for the elderly. Despite widespread deinstitutionalization of the chronically mentally ill there continues to be inadequate predischarge planning and followup care. The Mental Health Systems Act (S. 1177), as ordered reported by the Committee on Labor and Human Resources, is a comprehensive attempt to tear down some of the public policy barriers preventing the effective coordination of community-based health, mental health, and social services. It should lead to a

more effective allocation of our increasingly scarce health resources while making current mental health programs somewhat more responsive to the mental health problems of older Americans. While on balance we support the current version of S. 1177 we have some serious reservations concerning Title II—Community Services. Primarily, we are concerned that inadequate funding is authorized for a broad array of community services. We believe that there is a need to focus more sharply on priority areas of concern at the expense of a less ambitious range of support services. Limited resources need to be targeted more specifically on special problems of priority population groups. In this respect, the special mental health problems of older Americans stand out in clear relief. Yet the magnitude of the service options for the elderly outlined in section 204 (Services for Elderly Individuals) highlights the woefully inadequate funding levels authorized for title II ($400 million in fiscal year 1982). Moreover, overall funding for services to the chronically mentally ill gets off to a dangerously slow start, only 10–20 percent of title II funds in fiscal year 1982. In our opinion potential contractors have been given too much discretion and service options have been insufficiently targeted.

On a different level, we frankly are quite concerned about the need for the elderly to compete for limited funding with other traditionally powerful constituency groups. This structuring of the contracts process may result in only a perpetuation of the present trend of existing programs not serving the growing mental health needs of the elderly. Our associations are also disappointed that special incentives (e.g., tax credits) for self-help and family support systems have not been included within S. 1177.

We are hopeful, however, that there will be strong support for educational efforts to break down the stigma the elderly attach to mental health services. One approach to this problem which we support is the delivery of mental health services in such nontraditional settings as senior centers or health clinics. The intent should not be to duplicate CMHC services in areas where they exist but to provide the elderly better access and to facilitate treatment.

I would also like to add our associations' support for title III of S. 1177, the Patient's Bill of Rights. This provision should provide long overdue protection to the institutionalized mental patient. We believe that it deserves broad-based support.

A primary factor behind the lack of responsiveness of current programs to the mental health problems of the elderly is the insufficient flexibility of these programs. Our associations therefore view those provisions of S. 1177 that would provide linkages between physical health facilities/programs, mental health facilities/programs and nursing homes of special significance. As we have noted, linkages, aggressive outreach efforts, effective case management, and inservice training for nursing home personnel are especially important given the presently accepted practice by general practitioners of admitting elderly patients with mental disorders directly to nursing homes without the patient having any contact with the mental health system. This disturbing trend is being compounded by the transition of the deinstitutionalization movement into the transinstitutionalization movement. Simply stated, our nursing homes are not providing their mentally infirm patients with needed mental health services. This situation will only intensify with the graying of our population and the otherwise rapid expansion of our Nation's nursing home population. Clearly, this has to be the priority concern of our mental health care system.

At the same time, health manpower reauthorization legislation is the most appropriate vehicle by which to counter the pervasive age discrimination now practiced by our physicians, psychiatrists, and other mental health professionals. Incentives need to be established and training programs expanded to draw these professionals into geriatrics. Furthermore, cooperative agreements among CMHC's, area agencies on aging (AAA), nursing homes, and boarding homes are almost nonexistent. The National Institute on Mental Health (NIMH)'s Center for the Study of Mental Health and the Aged (CSMHA) does have a very limited number of pilot programs linking CMHC's and AAA's for the delivery of special mental health services for the elderly. However, these programs are funded by the Older Americans Act and title XX of Social Security, therefore resources are limited. We expect that title II of the Mental Health Systems Act (S. 1177) will significantly expand the resources available for such programs and in the process facilitate a much greater degree of interaction between mental health and aging professionals. The end result will hopefully be a greater degree of aging expertise among mental health professionals.

Finally, we believe the application procedure contained within section 215 of S. 1177 provides sufficient flexibility for local applicants and the State mental health agencies. This belief is a product of the realization that the State agency must have the primary management function over contracts for services in order to meet its mandated health planning responsibilities and that the State agency is most often best able to judge the mental health needs and resources of the State.

Our associations appreciate having this opportunity to express our views on barriers to the effective delivery of mental health services to the elderly and specifically on the Mental Health Systems Act (S. 1177). We look forward to continuing to work with the committee toward the goal of making our mental health delivery system more responsive to the needs of older Americans.

Senator PRYOR. Our next panelist is Clarence Perkins. Clarence is not only a personal friend of mine of long standing from the State of Arkansas but also Clarence Perkins has been in the trenches and on the frontline as a director of a community mental health center in southeast Arkansas. We asked him here today because we felt that he would share with the other members of our panel some of the day-to-day problems and challenges that he faces and his colleagues face on a daily basis.

Clarence, we are glad that you are here. I understand that you have a statement. We would like to have the entirety of your statement for the record. This applies, of course, to the previous two speakers. We hope that you will make a short statement and then we will have questions later.

STATEMENT OF CLARENCE W. PERKINS, WASHINGTON, D.C., MEMBER, PUBLIC POLICY COMMITTEE, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

Mr. PERKINS. Thank you, Senator Pryor.

I will submit my written statement for the record and summarize.

Senator PRYOR. Without objection, so ordered.[1]

Mr. PERKINS. I am certainly aware of your involvement in the services to the elderly for a number of years and I would like to maybe respond to two or three questions that Senator Heinz asked prior to his leaving in regards to some cost studies that have been made. There have been some cost studies made and I would like to briefly just mention three or four of them.

First, the potential savings that adequate mental health services lower the cost of other services is as much as 50 percent per patient. For example, in Texas, a longitudinal study demonstrated that subsequent needed treatment of mental illness resulted in a reduction for patients over 65 in patient facilities from 111 days to 53 days, reducing the costs more than $1.1 million.

The Group Health of Washington indicated that patients treated by mental health providers reduced their nonpsychiatric cost within the HMO by 30.7 percent. Also, the Kaiser Plan of California estimated savings of $250 per year for each patient receiving psychiatric treatment. The Blue Cross of Western Pennsylvania assessed the medical/surgical utilization of group subscribers who use therapy with outpatient benefits with the comparison group of subscribers for whom such services were not made available. The medical/surgical

[1] See page 106.

rate was reduced significantly. A monthly patient was reduced more than one-half, from $16.47 to $7.06.

Then the Aetna Life & Casualty Co. of Hartford, Conn., conducted a pilot study to determine the impact of partial hospitalization benefit and estimated they saved more than $255,000 for the 31,000 patients involved. I am sure that the National Institute of Mental Health will work toward some of these savings.

I could go on and on and on but we have submitted prepared testimony. I agree with some statements that have already been made. I feel that the people in the community mental health centers across the country are going to have to change their approaches to some extent. We no longer are going to sit behind a desk and wait for the elderly to come in but we are going to have to take the services out to where the elderly are.

Being a nonprofessional myself and strictly an administrator, I can look at it from that standpoint. We have to take the service to where the people are. Plato said a long time ago, "My age is my age and it is not my limitation." I also agree that we can use people to treat their peers, so to speak, and by doing this we don't necessarily have to expand our medical schools and train additional psychiatrists, social workers. We can also use the elderly as we have in the rural areas of America and are using some nonmedical people simply because some professional people are not there and they are not available. We can provide a lot of inservice training to provide some of these services.

Thank you.

Senator PRYOR. Thank you, Clarence. I will have some questions after a while but I am going to complete our panel before I ask the panel members, including yourself, some questions.

David Sandler is with us today. David, we wonder if you would like to make a short statement and then we will go to the next one.

STATEMENT OF DAVID SANDLER, WASHINGTON, D.C., DIRECTOR OF GOVERNMENT RELATIONS, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

Mr. SANDLER. Thank you, Senator. I will be brief and just use the remaining 5 minutes of Mr. Perkins' time.

Naturally we do want to thank you for the attention that you are focusing in this area and in particular we are very grateful for the help of Senator Heinz who for years as a Congressman and as a Senator has attempted to change the law and bring reform to our medicare system which from all the panelists today have testified discriminates very badly against the mentally ill.

Specifically I would like to make a couple of recommendations from my experience in working on the Mental Health Systems Act. This hearing is called at a very appropriate time. The Mental Health Systems Act has passed full committee and is on its way to the Senate. At this time perhaps, Senator, your committee can make some specific recommendations so that there will be prepared amendments on the Senate floor to make some changes in the Mental Health Systems Act which you and the groups here would advocate.

In particular, we heard testimony today concerning the areas of outreach and stigma. I would hope that something could be put into the

Mental Health Systems Act to provide sufficient funds for outreach and to do something about the stigma of mental illness which currently is preventing many of the elderly from coming in for treatment. We would hope, Senator, that your committee and the various individual members of the committee who serve on the Appropriations Committee and the Finance Committee will go through with the recommendations that are brought out in today's hearings and go back to their respective committees and work with those recommendations. We would hope that this committee would work toward the swift passage of the Mental Health Systems Act in the Senate and in particular the title on advocacy.

It is very important that we get funding for this bill for the Mental Health Systems Act in the appropriations bill. The funding, as we all know, is very limited. Now, if we are put on a continuing resolution, the money that will be available will be more limited and there won't be money for new mental health programs. This is particularly true in the area of distress which means many CMHC's will have to begin limiting their services and cutting services in order to keep their doors open. We are very fearful that many services that they will have to cut in order to keep their doors open will be services for the elderly.

We also hope that this committee will work very closely with the Department of Health and Human Services in the development and formulation of their plan for the chronically mentally ill. We hope there will be going interaction between this committee and the administration and that the committee will not wait until a nice little book or pamphlet is presented at the end of the study. Various mental health organizations have gotten together and are forming our own plan. We are also going to be working with the administration and we hope that this committee will do the same.

Thank you.

Senator PRYOR. Without objection, the statement of Mr. Perkins and Mr. Sandler will be entered into the record at this point.

[The statement of Mr. Perkins and Mr. Sandler follows:]

PREPARED STATEMENT OF CLARENCE W. PERKINS AND DAVID SANDLER

Recognizing the necessity to respond to the unmet needs of the mentally ill in this country, President Carter formed a Presidential Commission to analyze our mental health system within 1 month after coming to office. After a 1-year study, the President's Commission reported that a substantial number of Americans do not have access to mental health care. This was found to be particularly true for racial and ethnic minorities, children, and the elderly.

The President's Commission found that the prevalence of mental illness and emotional distress was higher among those over age 65 than those in the general population. They estimated that approximately 25 percent of older persons have significant mental health problems. Consequently, the Commission focused on the unmet mental health needs of our senior citizens and reported the following: "The elderly are subjected to multiple psychological stresses brought about by such things as social isolation, grief over loss of loved ones, and fears of illness and death. Yet there are almost no outreach efforts or in-home services in existing mental health programs to bring them into contact with the kinds of services they need. The personnel who are available to help them are often inadequately trained to address their special concerns. Instead, we confine our older citizens to nursing homes where good mental health care is seldom available."

As introduced last year in Congress, the Mental Health Systems Act, S. 1177, is a response to the report issued by the President's Commission. This bill will bring some degree of flexibility into the community mental health center program,

and make it possible for the Federal Government to target money for programs for the elderly.

Nevertheless, there is a great deal of discrimination against the mentally ill in various Federal programs which hampers community mental health center efforts to provide appropriate services to the elderly. Even medicare, designed primarily to help the aged, reflects this pattern. Medicare coverage is so limited for outpatient mental health services that for many CMHC's it is more costly to set up the accounting and billing arrangements under title XVIII in order to recoup minimal reimbursement for services for the elderly, than it is to provide such services for a nominal charge.

The major problem with medicare for CMHC's is that outpatient reimbursement is not made available to centers as provider agencies, but only for services furnished by physicians. This excludes from payment any service furnished by another qualified mental health professional, unless a physician is on the premises and supervising such treatment. For rural programs which have great difficulty in recruiting full-time physicians and which rely on contracts for part-time services from psychiatrists or other physicians in the area, this is a major barrier to reimbursement. Even if the service qualifies for reimbursement, medicare requires a copayment for mental health services of 50 percent (in contrast to that for other illnesses, which is only 20 percent), and further limits the Federal contribution to $250 per patient per year. This means any individual requiring more than about 10 outpatient visits will exhaust his/her benefits.

The elderly, perhaps more than any other group in society, are most sensitive not only to the stigma of receiving mental health treatment, but also about receiving services free of charge. The lack of a benefit package for mental health treatment, therefore, deters many from seeking the help they need.

Another major defect in medicare law is its failure to recognize the importance of day treatment programs (partial hospitalization) which all community mental health centers furnish. Such programs can be a most effective alternative to inpatient treatment. Not only do they cost less per day of service, but by allowing the patient to continue to live in the community, they greatly increase the effectiveness of treatment. There have been several studies on the costs and effectiveness of partial hospitalization services. They indicate that patients referred for day treatment need fewer treatments compared to similar patients referred for inpatient services, and that partial hospitalization is clearly significantly less expensive than inpatient services per term of illness. Medicare, however, has no specific coverage for such services, athough it is my understanding that many hospitals are able to bill day treatment as an outpatient service. CMHC's, which do not enjoy the luxury of being providers under medicare, have no access to reimbursement for partial hospitalization.

There are similar problems in many other Federal laws which could provide funding for services to the elderly. For example, medicaid does not require States to provide reimbursement to CMHC's, although that is an optional service. Many States also discriminate against mental health treatment under medicaid by setting arbitrary limits on the lengths of treatment.

The elderly also form a large part of the population which has been and continues to be discharged from State institutions. In this respect, they are also hurt by the failure of many other health and social services programs to deal adequately with the needs of the mentally ill. For instance, this population needs access to housing, rehabilitation programs, and social services to enable them to readjust and begin a successful, independent life in the community. In addition, of course, many also need aftercare mental health services which should be available to them from a community mental health center.

State and Federal programs, however, designed to provide low-income, or handicapped individuals with housing, rehabilitation, or social services were not designed with the mentally ill in mind, and the pattern of funding in these programs shows clear discrimination. Only in the last few years has HUD made significant moneys available to assist communities to provide the mentally ill with adequate housing, and this money is coming from a demonstration program with no guarantee of continuation from one year to the next. The program itself has been quite successful; but a long-term commitment to enable the deinstitutionalized population to find adequate community living arrangements is needed.

Similar problems exist in the rehabilitation programs and social services funded under title XX. The picture nationally is very spotty. Where an agency, or a constituency, working on behalf of the mentally ill has been aggressive

and active in seeking these moneys, and where State officials have been sympathetic to their needs, they have had some success. In some States, title XX has provided significant money to assist the elderly mentally ill, in others it has provided virtually none. Also, even when advocates for the mentally ill are able to tap these funds, it is frequently found that at the first sign of budget constraints, the services for the mentally ill are the first to be hit. Just recently, with the shortage of title XX funding, Texas initiated action to eliminate altogether its funding of social services for the mentally ill in community mental health centers.

Taken together, this pattern of discrimination in some Federal programs, and lack of consideration of the mentally ill in others, results in a disorganized patchwork of services for the mentally ill elderly at the community level. It is extremely hard for the administrator of a local community program to put the pieces back together again and develop the comprehensive package of services required by this population group. Ironically, the resources are there—it is just so hard for us to find them.

It is significant that the Senate Special Committee on Aging has decided to examine the issue of mental illness among the elderly. This has been a problem ignored for too long. Senility should no longer be used as an excuse not to treat and cure mental illness in our elderly population.

Senator PRYOR. Our next panelist is Jim Noble. Jim is here representing the State mental health organizations in the 50 States.

Jim, we are proud to have your statement and presence today.

STATEMENT OF JAMES W. NOBLE, TALLAHASSEE, FLA., GERONTOLOGY PROGRAM CONSULTANT, MENTAL HEALTH PROGRAM OFFICE, STATE OF FLORIDA; CHAIRPERSON, REPRESENTATIVES OF STATE MENTAL HEALTH PROGRAMS FOR THE AGED, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Mr. NOBLE. I would like to address an item that has been mentioned previously. One of the major current efforts of the Federal Government now underway on behalf of the mentally ill aged is the development of a national plan for the chronically mentally ill. A high portion of the chronically mentally ill are aged persons.

As far as we are aware, Mr. Chairman, the Congress has not been involved in this significant effort affecting the mentally ill aged. Because the principal thrust of the national plan involves modifying a number of statutes of the United States, it would seem to us that this Senate committee would have a critical interest in the issue and the goals of this plan. The plan is in the development stage right now by two major components of HHS. Those components are the National Institute of Mental Health and the Health Care Financing Administration. The plan is scheduled for final review by the HHS Secretary in August.

It is our recommendation that this committee demonstrate its concern for deinstitutionalization, treatment, and residential support of the mentally ill aged by requesting the Secretary of HHS to keep this committee informed periodically of progress in the development of the national plan for the chronically mentally ill and how its provisions will affect the elderly.

Thank you. I ask that my prepared statement be entered into the record.

Senator PRYOR. Without objection, so ordered.

[The prepared statement of Mr. Noble follows:]

PREPARED STATEMENT OF JAMES W. NOBLE

Mr. Chairman, I am here before you today representing the 50 State government health agencies.

I am the gerontology program consultant for the Mental Health Program Office, State of Florida and I am the chairman of the Aging Division for NASMHPD.

State government mental health agencies are heavily involved in treatment, rehabilitation and residential care of the aged who are mentally disabled.

State government mental disability budgets are about $6 billion a year, operating or supporting over 12,000 programs and facilities. A substantial part of these budgets and services are devoted to care of the aged.

We come before you today with recommendations that apply only to concerns of the mentally ill aged that might be met by actions of the U.S. Congress.

One of the major current efforts of the Federal Government now underway on behalf of the mentally ill aged is the development of a "national plan for the chronically mentally ill. (A high portion of the chronically mentally ill are aged persons.)

As far as we know, unless you advise us otherwise at this time, Mr. Chairman, the Congress has not been involved in this significant effort affecting the mentally ill aged.

Since one principal thrust of the national plan involves modifying a number of the statutes of the United States, it would seem to us that this Senate committee would have a critical interest in the issues and goals of the plan.

The plan is in development stage right now by two major components of HHS (formerly HEW). Those components are the National Institute of Mental Health and the Health Care Financing Administration. The plan is scheduled for final review by the HHS Secretary in August.

It is our recommendation, Mr. Chairman, that this committee demonstrate its concern for deinstitutionalization, treatment, and residential support of the mentally ill aged by requesting the Secretary of HHS to keep this committee informed periodically of progress in the development of the national plan for the chronically mentally ill.

This would give the U.S. Senate a continuing perspective on what objectives the Federal agencies envision in terms of statutory changes which must be addressed ultimately by you and your colleagues.

For your guidance, Mr. Chairman, our own association, in conjunction with most of the major national mental health organizations concerned with the mentally ill aged and the chronic patient, will next week be submitting to HHS and to the White House our own separate proposals for a national plan. It is our hope that our own State-local-consumer plan will be incorporated into the Federal effort.

Our plan proposal covers six major areas for proposed cooperation between Federal, State, and community levels in care of the mentally ill aged who are chronically ill: (1) Improved administration of programs; (2) better use of institutional resources; (3) development of components of continuum-of-care; (4) incentives to promote community support; (5) removal of barriers to care in the community; and (6) prioritization in funding and legislation.

Under the provisions of our national plan, Mr. Chairman, come a whole host of proposals involving the mentally ill aged. Most of these are issues that must eventually be addressed by Congress in the Social Security, Housing, Rehabilitation, and Mental Health Systems Acts.

I will not take your time today, Mr. Chairman, to describe all of the issues, but if the chairman so desires, we will be happy to make available to the committee next week a copy of the national plan as developed by the State mental health directors and supported by most of the national health organizations.

Our collective effort to develop a national plan is perhaps the single most important development this year in the care of the mentally ill aged.

There are several other matters we feel should be highlighted here today, Mr. Chairman.

We ask the Senate, was it the intention of this body when it passed the Social Security Act Amendments in 1967 creating medicare and medicaid, to label persons of any age discharged from a mental hospital as continuing to be mentally ill, thus, in many instances depriving them of Federal title 19 support when cared for in community residential centers?

This is a serious funding discrimination which we call upon this committee to investigate.

The practice today is that, when a person is discharged from a psychiatric institution and takes up residence in a skilled nursing home or intermediate care facility, that person frequently loses his or her entitlement to medicaid support.

This loss of entitlement is by virtue of an HHS edict; an administrative order published by HCFA. It is Federal agency interpretation of congressional intent and it is our recommendation that Congress make its intention clear.

Our question, Mr. Chairman, is: Was it the intent of the U.S. Senate at the time you enacted title 19 of the Social Security Act, to brand a 12-bed community residence caring for 7 deinstitutionalized State mental hospital patients as an "institution for mental diseases"? (This is an example).

Did you intend that persons suffering from organic brain syndrome, who are being treated by internal medicine or neurology specialists for an organic or physical disorder, did you intend that these persons forever be labeled as mentally ill, and thus lose their Federal entitlement?

The question of whether or not in the eyes of the Federal Government organic brain syndrome is a neurological or mental illness has critical funding overtones. We urge that your committee study this issue and consult with the National Institute on Aging.

What was the intent of the Senate when in 1967 it employed the term "institution for mental diseases" in the Social Security Act? We ask that your committee review congressional intent with respect to this issue and determine whether or not the regulatory interpretation by HCFA is in conformance with or contradictory to congressional intent.

In summary, Mr. Chairman, we call to this committee's attention these matters we consider to be of the highest priority in the treatment and care of the mentally ill aged: (1) The national plan for the chronically mentally ill, now in development, contains most of the major proposals the Congress must address in the 1980's for the mentally ill aged. (2) Congress needs to review its intent in regard to certain Federal entitlements to persons suffering from organic brain syndrome (an organic not a mental illness); when persons diagnosed as OBS reside in a community residence did the Congress intend that the Federal agencies define that as an institution for mental diseases—thus depriving all its clients of medicaid support?

Mr. Chairman, we thank you for your courtesy in hearing our proposals today and I stand ready to respond to any committee questions.

Senator PRYOR. Thank you very much.

We have with us a very outstanding member of our committee, Senator Percy of Illinois. Senator Percy, we would like to call on you at this time for a statement or for questions of any of the witnesses. We understand also that you have one of your constituents here as one of the panelists this morning.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator PERCY. Mr. Chairman, I thank you very much indeed. I do wish to welcome a very distinguished panelist.

I would ask unanimous consent that my opening comments be incorporated in the record.

Senator PRYOR. Without objection.

Senator PERCY. I would particularly like to welcome not only all of the panelists but especially Dr. Jack Weinberg, a fellow resident of Illinois and one eminently qualified to speak on the subject before the committee. He has served as the president of the American Psychiatric Association and is presently administrator of the Illinois Mental Health Institutes. Next year he will become president of the Group for the Advancement of Psychiatry. In the field of aging, Dr. Weinberg has been the spark behind the establishment of APA's Council on Aging on which he now serves as chairman.

[The prepared statement of Senator Percy and his introductory statement for Dr. Jack Weinberg follow:]

PREPARED STATEMENT OF SENATOR CHARLES H. PERCY

Mr. Chairman, an estimated 25 million older Americans make up 11 percent of the population. Approximately 5,000 Americans celebrate their 65th birthday every day. And current population trends are projecting an increasingly aging society, which will result in more of us making demands on limited resources. One of the major challenges of the 1980's will be to mold a national policy on aging, a policy which deals with the broad range of issues facing our elderly today, and one which will deal with the projected needs of an aging society.

The health and well-being of elderly Americans is an essential component of this policy. Unfortunately, mental health care for the elderly has been the stepchild to our health care delivery system. We have found that a need exists for the mental health care of the elderly. The President's Commission on Mental Health found that as much as 15 to 25 percent of the elderly have significant symptoms of mental illness; 25 percent of all suicides are committed by people over 65 years of age and as many as 20 to 30 percent of those labeled as senile can be treated and often helped. Unfortunately, for some of the elderly they are confined to nursing homes which may not meet their mental health needs.

Former Health, Education, and Welfare Secretary Elliot Richardson said, "Studies show a correlation between isolation and poor health which in turn lead to admission to long-term facilities—often at great expense to the public." Some of our current programs, such as the nutrition program, provide a necessary community contact for the elderly and help to prevent this isolation feeling. We should be encouraging outreach efforts to bring the isolated elderly more in contact with community services, which will help to prevent the unnecessary institutionalization of older Americans.

We have heard that one of the barriers to seeking and receiving mental health services for the elderly may be the stigma attached to not only the program, but also the age of the participant. Many elderly, who want and need help, are resisting becoming entangled with a mental health professional or any type of program which hints of mental health assistance. I am told that only a tiny percentage of older patients are handled by mental health professionals. On the other hand, what are mental health professionals doing to overcome this negative attitude? Are some professionals not interested in serving the elderly—believing that it is too late to help them. I reject the theory that once you reach a certain biological age you are too old to be helped. What is being done to eliminate the stigma so often attached to the aging process?

One of Congress response to meeting this Nation's mental health need was to set up community mental health centers throughout the country. These centers are required to offer 12 essential services, one of which is specialized services for the elderly. However, less than 4 percent of the units of services delivered by community mental health centers are for persons 65 or older. Later this year, Congress will have an opportunity to extend this program.

This is a tight budget year. Federal programs are under intense scrutiny. As far as all of our Federal mental health programs are concerned, we need to stretch the limited Federal dollars available for these programs for their maximum output.

I am pleased that the committee will be exploring the barriers which exists to offering mental health services to the elderly. It will provide us with an opportunity to review the effectiveness of existing programs, as well. It is essential that our outreach efforts overcome the barriers to services in order to deal with the mental pain and anguish the elderly have been experiencing without proper attention.

INTRODUCTORY REMARKS BY SENATOR CHARLES H. PERCY FOR DR. JACK WEINBERG

Mr. Chairman, it gives me great pleasure to introduce a fellow resident of Illinois, and one eminently qualified to speak on the issues before the committee today, Dr. Jack Weinberg.

Dr. Weinberg's credentials both in the field of psychiatry and aging are well known. He has served as the president of the American Psychiatric Association, and is presently administrator of the Illinois Mental Health Institutes. Next year, he will become president of the Group for the Advancement of Psychiatry,

an association from which we have heard over the years on this very issue.

In the field of aging, Dr. Weinberg has been the spark behind the establishment of the APA's Council on Aging, on which he now serves as chairman.

His writing and lecturing in the field of geriatric psychiatry have led many young men and women in the field of psychiatry to choose geriatric psychiatry as a profession. He has served as a watchful commentator on the efforts we have made and continue to try to make on behalf of the elderly and, more particularly, the mentally ill elderly.

I believe that Dr. Weinberg's experience in the fields of aging and psychiatry should provide a valuable contribution to today's hearing.

Senator PRYOR. Senator Percy, thank you very much for your contribution.

Our next witness is Sandford F. Brandt. Mr. Brandt represents, I would assume, the consumer mental health concerns here of this part of our population.

Mr. Brandt, we are proud to have you here. You may want to better define your constituency.

STATEMENT OF SANDFORD F. BRANDT, NORRIS, TENN., GOVERNMENT AFFAIRS COMMITTEE, NATIONAL MENTAL HEALTH ASSOCIATION

Mr. BRANDT. Senator, we represent the general public as well as the consumer, all of those who believe that they have an obligation and responsibility and an opportunity to do something to help their fellow citizens to keep them from becoming mentally ill, if possible, to help them if they do get mentally ill. We are a volunteer organization with chapters in about 800 communities.

I have a complete statement, sir, if I may hand it to the reporter at this time for inclusion in the record.

Senator PRYOR. Yes; your statement will be printed in the record [1] and you may summarize very briefly.

Mr. BRANDT. You specifically, Mr. Chairman, and other members of the committee, members of the panel, have very thoroughly documented the magnitude of the problem, the nature of it and so forth and I will not go into that at this time. The nub of this hearing is barriers to treatment of the elderly mentally ill.

Now I would like to suggest that there are three specific barriers. These are not institutional barriers that are of key importance. There is something that we in the Mental Health Association can probably do more about than the Congress. We are going to come to what the Congress can do next but the ones that we can do something about, the very first barrier is misdiagnosis not by professionals but by the members of the elderly themselves or their families. Misdiagnosis all too often is nondiagnosis—ignoring the problem, simply not paying attention to it.

The very symptom which when seen in the younger person will readily be recognized as a treatable mental illness when it shows up in an older person will be diagnosed or just simply taken for granted as irreversible senility about which nothing can be done and therefore nothing is done.

Senator PRYOR. Mr. Brandt, may I interrupt you there? I will have to leave now for the vote.

[1] See page 114.

Chuck, have you voted already?

Senator PERCY. No.

Senator PRYOR. I am going to leave the panel in charge of either Senator Percy or Bentley Lipscomb, the staff director. I will be returning in just a few moments but he is going to carry on as scheduled and we will have our interchange between all the participants at the conclusion.

Senator PERCY. Mr. Chairman, I want to say that Dr. Flemming is a long-time friend. Today, we really have a remarkable group of panelists who, through the years, have contributed so much to the committee.

Senator PRYOR. I heartily agree with you.

If you want to proceed, Mr. Brandt.

Mr. BRANDT. Thank you, Senator Pryor.

As I noted, the first major barrier that is unique to the elderly is not shared by the mentally ill of any other age group and that is misdiagnosis or nondiagnosis by friends, family, the elderly themselves and so forth, not to mention many of the primary care physicians but that is another subject.

A second major barrier to treatment providing services for the elderly or mentally ill is that of stigma. Now many young persons today will talk openly and frankly about emotional problems. To many of them it is no disgrace to have an emotional problem, there is no stigma attached to them for seeking help concerning their problem. However, this is not the case with my generation, a person 70 years old and older.

We don't want anybody to know that we or anyone in our family has ever had any emotional problems. That is, it is a closet illness if it is recognized at all. Nor can we let anybody know that we are seeking help. Therefore, as a general rule, your older people just don't seek help. This is a problem common to the elderly more so than other age groups.

Third is cost. I realize this committee is not the Finance Committee, the Appropriations Committee. However, as one of the earlier witnesses said, you can't avoid the question of cost. When a person is retired, most people put it this way. Most Americans are getting by on social security or social security plus a small pension. Most older Americans, that is. Cost of treatment is a real barrier to anyone who is no longer enjoying the income of his or her productive years.

Now those are three barriers about which we, in the Mental Health Association, feel we can do an awful lot through education—education of the elderly themselves, education of their friends and families, general public, primary care, physicians, health providers, and education of State and Federal legislators.

Now the role of the Federal Government as we see it, there are six specific steps that can be taken and should be taken by the Congress.

First: Greatly increase the prevention activities of the Federal Government.

We have a remarkable record of prevention in polio, smallpox, malaria. In the area of mental health it is dismal, I think, and there are many aspects of mental illness especially in older persons that are foreseeable and therefore are preventable. We do hope that the Government will do much more than prevention.

Second: Maintain the research momentum. During the past 4 years the level of research in mental health has gone up 40 percent and that

is remarkable. That is wonderful. However, when you look at this in comparison with other health research you see that of the total Federal health research dollar, 6 percent is going into mental health, notwithstanding the extremely widespread incidence of mental illness as has been brought out by other members of this panel earlier. A start has been made. I should not call it tokenism, I guess, but I will. There has been a start made in NIMH and they can certainly speak better to this than I can but we hope there will be a full-fledged office of prevention established very soon in NIMH.

Third: Complete the community services network. Now I am not going to get into the question of whether we need to get into the question of whether we need more CMHC's or we need more whatever kind of agency is going to come out under the new Mental Health Systems Act. We need something in every community in this country. To date I think about half the population that does need care does not have access to community mental health service under the CMHC Act. So we hope the Congress will speedily enact and fully fund all the programs authorized in this new Systems Act.

Fourth: End medicare discrimination. This has been mentioned by so many witnesses before me that I will not go into it further except to say that progress has been made, as Senator Pryor says, over in the other body. Both the Interstate and Foreign Commerce Committee and the Ways and Means Committee have reported out a bill which would end much of the medicare discrimination against the mentally ill and would for the first time grant CMHC's provider status. Over on the Senate side nothing has happened.

Fifth: Prevent perpetuation of discrimination. Every major national health insurance bill or catastrophic bill either incorporates or builds on medicare with its inherent discrimination. We certainly hope that if and when the Congress ever adopts some form of health insurance or catastrophic insurance that the pattern of discrimination against the mentally ill will not be perpetuated in that legislation.

Sixth: Improved private insurance. Legislation is pending in both the House and Senate to provide for certification by the Secretary of Health and Human Services of so-called medigap insurance; that is, private health insurance to supplement medicare. We urge this committee to do everything it can to see that the traditional discriminations against mental illness do not creep into that legislation or the regulations that implement it.

Thank you very much.

Mr. LIPSCOMB [presiding]. Thank you very much. Your prepared statement will be entered into the record at this point.

[The prepared statement of Mr. Brandt follows:]

PREPARED STATEMENT OF SANDFORD F. BRANDT

Mr. Chairman, members of the committee, my name is Sandford F. Brandt. I live in Norris, Tenn., and have been active as a volunteer in the Mental Health Association at the local, State, and national levels for some 25 years. I am testifying today on behalf of the National Mental Health Association and its more than 800 State and local affiliates throughout the Nation.

The Mental Health Association greatly appreciates being invited by the Special Committee on Aging, U.S. Senate, to testify at this hearing on the very relevant topic: "Aging and Mental Health: Overcoming Barriers to Service."

In our judgment, Mr. Chairman, there is no group in the United States today which, taken as a whole, faces more and greater barriers to mental health care

than the elderly. It should go without saying, of course, that our older citizens face all the barriers common to all age groups—and there are certainly enough of those. In addition they face many more, as our testimony will show.

Before identifying these barriers, and setting forth our recommendations for overcoming them, let me describe briefly the magnitude of the problem. Ten percent of all Americans are 65 or older. Yet among patients of community mental health centers, only 5 percent are 65 or older; among patients of psychiatrists in private practice, only 2 percent are 65 or older. From this one might conclude that the incidence of mental illness among our older citizens is far below average. On the contrary, it is far above average. Not 5 percent but closer to 25 percent of our older citizens suffer from some form of mental illness, mild or severe, fleeting or persistent, at any given time. Thus our older citizens are indeed underserved. Why? What are the barriers, the special barriers that cause this?

First, in my opinion, the greatest single barrier to proper care for our elderly mentally ill is one that is unique to the elderly. It is not shared with any other age group. Simply stated, this barrier is that of misdiagnosis, or, perhaps even more often, nondiagnosis. The very symptoms that are recognized as being those of a treatable mental illness when seen in a younger person will, when they show up in an elderly person, often be diagnosed—or not diagnosed at all but simply taken for granted—as irreversible senility about which nothing can be done. And therefore about which nothing is done.

Second, a problem that is not entirely unique to the elderly but is far more prevalent among that age group is the problem of stigma. Today's young people, and many of today's middle aged as well, are relatively open about emotional problems. Many attach no stigma to having a problem and no stigma to seeking help. This is not the case with persons of my generation, those in their 70's and older. People of my generation all too often cannot bring themselves to admit to having a mental problem and cannot afford, at least in their own eyes, to have it known that they are seeking professional help. So they simply do not seek help.

Third, another problem more common to the elderly than to other adults is cost of treatment. Most retired persons are getting by on social security or on social security plus a small pension. The cost of treating mental illness for someone no longer enjoying the income of his or her productive years is indeed a barrier.

Those, then, are the three principal barriers to mental health services for the elderly, above and beyond the barriers common to all age groups, as we in the Mental Health Association see them. Now, what are the solutions? What does it take to overcome these barriers?

First and foremost among all possible solutions is education: Education of older Americans themselves, education of their friends and families, education of primary-care health providers, education of State and Federal legislators. Your Mental Health Association regards this as its primary role: To promote full understanding of the nature and extent of mental illness, of the genuine opportunities for preventing it, and of the nationwide need for readily available and economically feasible services for those who become mentally ill.

I now turn to the role of the Federal Government, specifically the role of the Congress. We see six definite steps the Congress must take to remove the barriers to adequate mental health care for older Americans.

One: Greatly increase prevention activities. Some mental illness can be prevented. We already know this. This is especially so among older people because so many of their emotional problems are predictable: The shock of retirement, loss of spouse, reduced income, waning physical health, removal from familiar surroundings. These are all foreseeable and can be prepared for thus reducing, at least to some extent, the stress that so often triggers an emotional breakdown. These, of course, are a few of the most obvious examples. The efforts of our Federal Government in the field of prevention—outstanding in the cases of polio, smallpox, and malaria—are meager and fragmented in the area of mental illness. What is needed is a full-fledged office of prevention in the National Institute of Mental Health, staffed by a core of dedicated professionals schooled in the concept of prevention vis-a-vis treatment.

Two: Maintain the research momentum. Federal expenditures for mental health research have increased 40 percent in the last 4 years and are now up to $145 million including $6 million for aging. Notwithstanding this promising trend, research in mental health still accounts for less than 5 percent of the total Federal health research dollar. Contrast this with the fact that one-third of our

hospital beds are occupied by those diagnosed as being mentally ill; contrast it with the conclusion of the President's Commission on Mental Health that, not 1 in 10 as we had previously believed, but 1 in 7 Americans is disabled to a greater or lesser extent by some form of emotional distress.

Three: Complete the community services network. Today, 17 years after Congress started the program, about half the people in the United States do not have access to a federally assisted community mental health center (CMHC). We hope the Congress will speedily complete action on the new Mental Health Systems Act, now reported out in both Houses, and fund the programs to the limit of their authorizations. Meanwhile, it should be noted that many proposed community mental health centers have been organized, and have been approved by NIMH, but are still without Federal funding. I understand that in Florida alone there are some $5.4 million in approved but unfunded applications, $3.2 million in New Jersey, $1.7 million in Pennsylvania, $1.5 million in Ohio, not to mention other sections of the country. Lack of access to nearby community mental health centers is indeed a barrier.

Four: End medicare discrimination. Part B of medicare grossly discriminates against mentally ill persons in that it pays only 50 percent of their costs, rather than the 80 percent for other covered illness, and pays only up to $250 annual reimbursement ceiling, compared to no such ceiling for other illnesses. A further medicare barrier is the fact that although the medicare program and Federal grants for operating CMHC's are both products of the same Congress—the 88th Congress in 1965—the Social Security Act does not recognize CMHC's as primary providers eligible for reimbursement under medicare. Legislation to correct this and to greatly reduce the discrimination in part B has cleared both the Ways and Means and Interstate and Foreign Commerce Committees in the House; no action has been taken in the Senate.

Five: Prevent perpetuation of discrimination. All major national health insurances proposals or catastrophic health plans now pending either incorporate or build upon medicare, with its inherent discrimination against the mentally ill. Additionally, some of the catastrophic proposals impose stringent limitations on the amount of mental illness costs that may be included in the trigger amount. We hope this committee will do all it can not only to end existing discrimination but to make sure it does not get perpetuated in whatever health insurance plans may ultimately be adopted.

Six: Improve private insurance. Legislation is pending in both House and Senate to provide for certification by the Secretary of Health and Human Services of so-called medigap insurance, that is, private health insurance sold to augment medicare. We urge this committee with its demonstrated concern for the elderly mentally ill to make sure no discriminatory provisions are allowed to be included in either the legislation or the implementing regulations.

Mr. Chairman, that concludes the formal statement of the Mental Health Association. I shall be glad to try to answer any questions members of the committee may have. Again, thank you very much for inviting us to testify and please call on us if there is any way we may assist you.

Mr. LIPSCOMB. Dr. Weinberg.

STATEMENT OF JACK WEINBERG, M.D., CHICAGO, ILL., PROFESSOR OF PSYCHIATRY, RUSH MEDICAL CENTER; ADMINISTRATOR, ILLINOIS MENTAL HEALTH INSTITUTES

Dr. WEINBERG. First I would like to thank the Special Committee on Aging of the Senate for providing me the opportunity and the privilege of appearing before it, and to thank Senator Percy in particular for his very kind words about me.

So much has already been stated by the members of the panel, both across the aisle and here on this side. So much has been said that I was going to say that I should really be able to say everything has been said and I ought to lapse into silence. However, you are not going to get a psychiatrist to do so. I am going to make some comments that may not seem relevant or valid to what has been stated so far, but I would like to add to the discussion.

Like my good friend, Dr. Ewalt, I am in the dubious position possibly of using euphemistic terms that are being utilized both by a provider and a consumer. I hate the word "consumer." I must tell you that because visions come before my eyes of being consumed as a provider by some sort of a fire that is going to come, and maybe that is what makes us so reluctant in providing something before we are being totally consumed.

I would like to indicate that I do not like to provide statistics because, as a psychiatrist, the suffering of one individual should be sufficient for me to be concerned about, and the suffering of one individual is a tragedy to that particular individual and to the family of that particular individual. The suffering of many becomes a statistic, and then one somewhat alienates oneself from it, so it should be sufficient for all of us to be concerned whether we are in large numbers or not, and it is obvious that we are going to have an increased number of aged people in our society.

I venture to say that all the people sitting here, whether they are around this table or to the left of me, will be individuals that have a very good opportunity of letting into their findings, and that is due to the fact that in their altered state, medicine and technology have provided that more of us live to a riper old age due to better nutrition, better education, better preventive measures by such things as regular blood pressure examinations and cardiovascular examinations, and people are more educated to try to go to their physician more frequently.

What bothers me about most of the things that we are talking about is that in giving statistics and in looking at the elderly from a statistical viewpoint, we do not enter into the understanding of the inner life of these individuals because every older person has an inner life that needs to be explored and understood if we are to be able to help. What I am trying to say is that we are trying to apply the same rules and the same modalities of therapy and intervention to all people when the variation in the human experience is so enormous that it is as enormous as there are the variables or as enormous as there are human beings on Earth.

We see the emotionall ill and mentally ill aged person as a disturbed person who is alienated from the society and whose behavior is bizarre enough to make him or her appear to be a stranger in our midst. I would like to propose that if their behavior is strange and odd to us and if they are alien to us, we in turn appear as alien and strange to the disturbed human being. They are certainly as afraid of us as we are afraid of their bizarre behavior, and we ought to understand that, we ought to educate our people to understand that this takes place.

There is also the fact that it is stated, and it is sad, I think with accuracy that many of us as physicians do not treat the chronically ill elderly, and indeed we have neglected them. I offer to you the reason is not only financial, because that has been exploited to an *n*th degree, but the very fact that the elderly long-term ill, emotionally ill people threaten the doctors and the care givers with omnipotence, the ability to feel that it can actually help despite the fact that help is possible, and they hold a mirror in front of our faces as to what is going to happen to us and so we try to avoid them. Those are issues that we need to educate people about.

I would like to also attempt to correct a feeling that exists that if indeed we deinstitutionalize and place the people into the community, then the funding from the institutions should go to the communities and to the community mental health centers. One of the reasons that the large State hospitals have become warehouses has been the fact that there has not been sufficient funding for those hospitals to take care of the people there.

When I first started as a psychiatrist as a resident, I was given 600 patients in a great big mental institution for the State of Illinois that Mr. Percy would know about; 600 patients to take care of would mean that I was unable to give care to anyone.

As the institution empties, we increase the number of psychiatrists, and the care of them takes more funding so we cannot experience the luxury of taking money from the institutions and then provide it to community mental health centers. Then it is to be an extension of both. Philosophically the institutions have been created as a morale treatment of the mentally ill to put them into asylums. The word "asylum" has a terribly important meaning to us all. We did not provide the funding, so now another moral issue is to take them out of the institutions and place them in the community.

What happens, there are, of course, some false issues that they place. We do not prepare the communities into which we send these people to be able to accept them. The community has a certain amount of tolerance for deviant behavior within its presence, and to place many elderly emotionally ill, mentally ill people in a particular community creates a hospital within the community just as much as the State hospital, without the benefits of a State hospital.

Anybody who saw the documentary last night on public television has seen what is happening in the community. Before those centers fail, we need to provide them sufficient funding. We need to provide them the opportunity to have people who are trained, and there I cannot stress sufficiently the need for more training of more professionals. I would like to state that while I agree with my colleague, Dr. Klerman, I think, however, not enough in the priorities has gone to greater education to those who provide care to the mentally ill aged, and more needs to be done from the National Institute of Mental Health.

I know that in any institute we are training fellows in geriatric psychiatry. I would like to tell Dr. Ewalt that, and I don't know how it speaks for our Army, but the U.S. Army is sending one of its physicians to our institute to be trained in geriatric psychiatry at their expense. I don't know whether our Army is aging or our generals are aging. I don't know what is happening or what is going on over there, but we are happy about that.

I would like also to ask Mr. Benedict or to indicate that possibly he was unable to answer the question of Senator Pryor as to how much is of the mental health component in the centers that are being proposed. I just know that many of those proposals have been spearheaded by psychiatrists rather than by other medical people within the 40 applications that you have received for center planning. Am I correct in that?

Mr. BENEDICT. That is correct.

Dr. WEINBERG. I have a statement, as if I didn't make a statement—a much bigger one to present to the committee for inclusion in its record.

Mr. LIPSCOMB. The statement will be included in the record at this point.

[The prepared statement of Dr. Weinberg follows:]

PREPARED STATEMENT OF DR. JACK WEINBERG

Mr. Chairman, members of the committee, I am Jack Weinberg, M.D., a psychiatrist from Chicago and administrator of the Illinois Mental Health Institutes. While appearing before you today in a private capacity, I should mention that I also serve as the chair of the Council on Aging of the American Psychiatric Association, a medical specialty society representing over 25,000 psychiatrists nationwide. I have also had the honor of serving as the president of that association.

I welcome the opportunity to appear before you today to discuss the current state of the art in providing psychiatric and other mental health care services to our Nation's elderly, and welcome even more the opportunity to present my views on what we should be doing to further meet the needs of this growing, and hurting population.

Naturally, many of my colleagues in the field of geriatric psychiatry and I were gratified to learn that the Carter administration, when first in office, took an interest in and was concerned with the problems facing the mentally ill, and were equally gratified to note that the President's Commission on Mental Health, the group given the spearheading responsibility for this interest, stated in its preliminary report that "(I)n our society, individuals must have the opportunity to have their suffering alleviated insofar as possible and * * * no individual who needs assistance should feel ashamed or embarrassed to seek or receive help." Our good feelings continued as we read the recommendations of the President's Commission regarding the appropriate means of meeting the mental health needs of the elderly, one of the four groups determined to be unserved or underserved by our existing system of health care. Our gratification came as the result of our belief that at long last, the recommendations and promises of the past to help meet the treatment needs of the mentally ill elderly would be implemented, bring such individuals into the mainstream of our health care system, over a decade and a half after Congress adopted the Older Americans Act and its commitment to assuring the elderly a life of independence and dignity. At last, we believed this forgotten segment of our population would not be relegated to either the back wards or the back alleys.

However, since that time, we have seen few changes, our hopes frustrated again, and services still a promise, not reality. As our current laws are drafted, as new programs are being proposed, to provide health insurance (whether catastrophic or phased in comprehensive) to improve medicare or medicaid or to meet the special needs of the mentally ill, such as the Mental Health Systems Act, the likelihood of assuring that "suffering (is) alleviated insofar as possible" does not markedly change and will not until a wholesale series of changes are made to establish an intermeshed system of care for the mentally ill elderly.

To provide perspective on the issue, I would first like to paint a portrait of the mentally ill elderly, who they are, how many they are, what their general problems are. Next I would like to explain the existing barriers between these hurting people and treatment opportunities. Last, I hope to provide a series of recommendations to the committee for its consideration which I believe may begin to help assure that the elderly are afforded a full range of treatment services, and access to such services, should they require mental health care.

THE NEED FOR SERVICE

Most Americans over 65 years of age are well-functioning individuals with little or no evidence of mental disorders, 95 percent reside in the community. A significant minority, however, are of high risk to develop psychiatric symptoms or illnesses. The elderly have a high incidence of poverty, an increased incidence of serious physical disease, greater likelihood of losing loved ones, and a higher probability of lost status. Older persons are more apt to develop depressions, organic brain syndromes, mental reactions as side effects to medication and certain paranoid reactions. The predominant number of elderly suffer not from a single acute-term illness, but a constellation of problems, both physical and emotional, which, while treatable, are not characteristic or short-term acute illnesses.

Though comprising but 11 percent of the population, the elderly contribute over 20 percent of the Nation's suicides. Psychoses increase after 65, and even more so after 75. Organic brain disorders in severe form affect over 1 million elderly, and appear in less severe forms in an additional 2 million persons. Prevalence of depressive disorders in community-based (contrasted to institutionalized) elderly is at least 10 percent. All in all, 15 to 25 percent of older persons demonstrate significant symptoms of mental illness. Because the fastest growing segment of the American population is the group over 75 years of age, we can expect that the number of elderly with significant nervous, emotional, or mental disorders, will increase significantly over the next decade.

Despite an increased risk for mental disorder, the elderly are consistently underserved by both the private and public health care sectors. Only 4 percent of community mental health center patients are elderly. Private practitioners and clinics provide but 2 percent of their services to the elderly. In fact, less than 1.5 percent of direct cost expenditures for mental illness is provided for older persons residing in the community. Sixty percent of those elderly who are admitted to State mental hospitals have received no previous treatment for their mental disorder.

This data is particularly disconcerting because the considerable majority of these disorders are treatable and reversible. Indeed, the President's Commissions on Mental Health has noted that as many as 25 percent of those individuals determined to be senile actually have treatable, reversible conditions. Early diagnosis and treatment of emotional disorders can minimize their impact, and delay or prevent a worsening of the condition.

These facts have been thoroughly studied and are well established. The Age Discrimination Study of the U.S. Commission on Civil Rights reports that the elderly are grossly underserved in comparison to other age groups within federally supported community mental health centers. The President's Commission on Mental Health Task Panel on the Elderly states that the elderly are "unserved, underserved, or inappropriately served." The Secretary's Committee on the Mental Health and Illness of the Elderly and the U.S. House of Representatives Select Committee on Aging National Conference on Mental Health and the Elderly confirmed these findings and conclusions.

Yet the situation persists, and persists as the result of a combination of factors—reimbursement structures under Federal health care programs, the fragmented, disorganized system of health care and social service delivery available to the elderly, the misunderstanding of the cost of treating the mentally ill in general and the elderly in particular, the low number of psychiatrists, other physicians and other mental health professionals interested and trained to provide care to the elderly, and the continuing fear and stigma which still haunt the concept of mental illness.

BARRIERS TO CARE

We now know the prevalence of mental illness among the elderly. We now know that with adequate treatment opportunities, the vast majority of those elderly suffering from some form of mental disorder will improve. We also know that with timely early intervention, some difficulties may be avoided altogether.

At this juncture, I believe it important to review why there are barriers to the delivery of care, why the elderly are not adequately served by our existing system of mental health care delivery, and review the failings of our existing system of health care for the mentally ill. The reasons are multiple and complex. They include the relative lack of value of the elderly in our society, the stigma of mental illness; the lack of accessibility to and availability of needed services; insufficient means of financing such services; poor coordination of such services; and a lack of understanding of the nature and treatability of late-life mental disorders on the part of physicians (including many psychiatrists), and other mental health professionals, the elderly themselves and their families. I would like to detail each of these barriers to the provision of appropriate and necessary care to the mentally ill elderly.

The ageism which continues to exist within our society is best characterized by the perception that the elderly have served their use in life, and should therefore be consigned to the shelf. As Robert Butler, M.D., Director of the National Institute on Aging, has pointed out, this belief, this ageism, pervades the mental health community as well, and as such, acts as a major deterrent to caregiving. He notes: "Many psychiatrists and other mental health specialists share our

culture's negative attitudes toward older people, the pervasive prejudice I have called ageism which is the progress of systematically stereotyping and discriminating against people because they are old. Old people are categorized as senile, rigid, and old-fashioned in morality and skills. Ageism allows those of us who are younger to see old people as 'different.' We subtly cease to identify with them as human beings, which enables us to feel more comfortable about our neglect and dislike of them."

Coupled with the myriad of other factors cited above, ageism forms the basis for our failure to provide needed care to the mentally ill elderly.

But if ageism controls many of our attitudes toward the elderly in general, it is abundantly clear that an elderly person afflicted by emotional disorder is in double jeopardy. As many of you may have seen on public television last evening, the stigma of mental illness is still with us. The movement from the back wards to the back alleys continues, without adequate attention to the constellation of services required by such individuals. Part of this may be explained by the trend to deinstitutionalize too quickly without adequate preparation at the community level, but a major portion of this problem is the result of our feeling that somehow the mentally ill are not human, do not need care, are pariahs to be shunned by society. The elderly person is stigmatized twice, once by the fact of being old in an ageist society, and once again by the fact of mental illness.

Due to the stigma, fear and misrepresentation of mental illness, persons are reluctant to seek mental health care. Mentally ill persons are more likely than those with physical illnesses to delay or to reject early treatment. Today's elderly are from a generation when psychiatry and its implications were viewed negatively. To many, to be senile is a normal aspect of being old; to be gloomy and without hope for the future is viewed as normal, not a manifestation of depression. Such erroneous concepts must be erased not only from the tabla rosa of the physician and other mental health professionals, but also from that of the layman. Without ending the stigma of mental illness, placing it in its proper perspective, that it is oftentimes a treatable disease which may be ameliorated in the same way as many physiological difficulties may be resolved, we will continue to be frustrated, not only in meeting the treatment needs of those already diagnosed as mentally ill, but frustrated by the vast numbers of individuals who are too proud, too frightened, to accept the fact of mental illness and receive treatment for that illness.

Frankly, I believe the stigma of mental illness is being heightened further because the discrimination has become institutionalized—written in the medicare law, written in the restrictive language for treatment of mental illness contained in the health insurance legislation now pending before Congress and the restrictive measures contained in most private health insurance plans. All suggest that mental illness is grossly different from physical illness—not treatable, not reversible and not equally reimbursable when treatment is provided. The combination of such stigma with the pervasive ageism of our society renders care to the mentally ill virtually impossible. The combination of the stigma and ageism has allowed this Nation to continue to ignore a significant segment of its population, allowed Congress to twice discard the recommendations of a White House Conference on Aging regarding the need to improve the social and health care service delivery systems to meet the needs of the mentally ill elderly.

Because we have ignored the situation confronting the mentally ill elderly for so long, the treatment system today is badly fragmented. It is based on the medicare assumption that most illnesses are one which require acute inpatient treatment for short periods of time, and that if longer stay care is necessary, the most appropriate location for such care is a nursing home. This assumption is badly flawed. As this committee has heard time and time again, the aged do better when able to remain in their homes, in their communities, not when hospitalized or institutionalized.

Greater flexibility, other than that which is provided under existing medicare law, is necessary if we are to meet the various needs of our older population. We cannot rely upon the current system which, unfortunately, stresses the wrong types of care and encourages abuse of the very population it is designed to serve.

Of particular concern to me is the situation regarding the deinstitutionalization of the elderly into nursing homes or foster care facilities. While such changes removes the financial burden from the State, it does not constitute appropriate and adequate treatment. More often than not, foster care facilities,

67-899 O - 80 - 6

nursing homes, and welfare hotels provide no psychiatric services. No followup is provided. Indeed, there is a disincentive to nursing homes to write in the patient record that the patient is in care for a primary diagnosis of mental illness, for if more than 50 percent of the patients have such diagnosis, the nursing home may lose its certification. Indeed fewer than 10 percent of patients, in a sample of 60 nursing homes in nine States, were identified as having mental or emotional disturbances. When a team of mental health professionals investigated their clinical status, more than 70 percent of these patients had some degree of diagnosable dementia.

Though multiple layers of Federal, State, and local regulations have accumulated, nowhere does accreditation of a nursing home depend on its guaranteeing staff training in psychosocial assessment and management, uses and adverse effects of psychotropic mediations, or interpersonal relations; nowhere is a nursing home required to provide psychiatric consultation. The results of this are unnecessary suffering for patients, and rejection, abuse, and avoidable transfer of patients whose disorders could be treated.

I remind the chairman of my testimony before this committee several years ago regarding just this issue.

"Dr. WEINBERG. I criticized * * * the idea of transferring inordinately large numbers of people into nursing homes from mental hospitals. I was amazed when * * * the new Governor of the State of Illinois * * * announced he was going to release 7,000 elderly patients into the community. I didn't know who made the important clinical decision that these 7,000 people were not mentally ill.

"Senator PERCY. Don't you imagine that there is the possibility that the operators of these nursing homes organized into an association and an officer * * * put pressure on the State and other government officials to release patients so they want to fill beds? They have got stockholders' reports to show. They have got empty beds and they are going to fill them with bodies and maybe those bodies are going to have to come out of the mental hospitals. Don't you think that sets the pressure up then to fill those beds?

"Dr. WEINBERG. It certainly does. May I reveal something personally, that when I was asked to supervise this program 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."

There must be alternatives, and among the best are avoiding institutionalization in the first place, through early and appropriate intervention.

But even if our elderly mentally ill are allowed to remain in their homes, in their communities, provided the kind of physical and emotional environment conducive to treatment, poor coordination of services, and accessibility to services, thwarts the delivery of care. For example, statewide responsibility for planning mental health services for the elderly is often not clearly defined. Departments on aging may expect departments of mental health to take a leadership role, and vice versa. While we anticipate the health planning amendments to somewhat ameliorate this problem as it applies to the planning of treatment for the general population of mentally ill, there is nothing which will assure that the mentally ill elderly do not "fall through the cracks" of this system.

Multidisciplinary, comprehensive evaluations are provided rarely. The private sector often fails because of inordinate delays and poor coordination. For example, the disturbed elderly patient who attempts to see a primary care physician and a psychiatrist may not have a complete evaluation for several weeks—during which time the mental/physical conditions may worsen. Even when comprehensive evaluation programs do exist, many agencies and the elderly are unaware of them. Moreover, medicare will not reimburse for evaluation.

The community mental health center remains the primary treatment program outside the private sector, to which an elderly mentally ill person can turn for community-based services. However, as I have mentioned before, fewer than 4 percent of the patients seen at CMHC's are elderly. Clearly, medicare reimbursement is part of the problem. Yet another problem is the failure of the general practitioner to diagnose mental illness, again returning to the stereotyped picture of the elderly as senile, rigid, and confused.

There is generally no central focus where information of community-based treatment programs for the mentally ill elderly can be obtained. A lack of supportive services and information for families to assist family members in

helping an elderly relative, highlights another glaring deficiency. Dr. Robert Butler points out that in one recent study, 70 percent of intact families were willing, without help, to provide intensive personal care and services to severely disabled elderly persons returning home from the hospital for the first time. However, only 38 percent of these same relatives were willing to provide care without social supports after the second hospitalization. Existing mechanisms to overcome such difficulties exist, they are simply not utilized in an appropriate fashion. The networks are there, the information is there, but it is not being provided, again perhaps because the stigma of mental illness overrides concern and the willingness to help.

Last, we do not have adequate numbers of appropriately trained psychiatrists and other mental health professionals to meet the needs of our Nation's mentally ill elderly. There are fewer than a dozen federally funded programs which train psychiatrists to the special needs of the mentally ill elderly. I am proud to be involved, and deeply committed to one of them. However, very few psychiatric residents and psychiatrists see geriatric psychiatry as a worthwhile endeavor. This may be explained by ageism, gerontophobia, financial remuneration, etc. However, one of the major factors affecting this decision is the lack of role models who are in highly esteemed positions and who are respected by their medical colleagues as teachers, clinicians, and researchers. A report several years ago estimated that by this year, 10,500 psychiatrists alone would be needed to properly and effectively deliver the level of mental health care required by the elderly. Here it is 1980, this obviously has not been achieved. Moreover, with the number of medical students choosing psychiatry as their field of endeavor decreasing, and with ageism still a problem, although not to the same degree as 10 years ago, the chances of producing the trained phychiatric manpower to treat the elderly and to educate the public in general do not appear promising.

I cannot depart the issue of barriers to the provision of treatment to the mentally ill elderly without some discussion of the reimbursement mechanisms which in many ways serve as the underlying base to the other barriers hitherto mentioned. Reimbursement problems prohibit CMHC's from providing all the kinds of care required by the mentally ill elderly. Reimbursement problems restrict the willingness of private psychiatrists to accept elderly patients. Reimbursement problems have encouraged the use of State hospitals, nursing homes in lieu of either outpatient, home-based care or hospitalization in a private psychiatric hospital or psychiatric unit of a general hospital. Reimbursement problems have restricted the growth in number of geriatric phychiatrists. An article appearing in the New York Times[1] early this year raises some of the problems with reimbursement practices under medicare and I ask that it be included in the hearing record.

The costs associated with the reimbursement mechanisms under medicare are staggering in both human and economic terms and serve only to perpetuate the stigma of mental illness.

In 1974 the National Institute of Mental Health estimated the indirect cost of mental illness at nearly $20 billion. The study noted that "Indirect costs are the income or income-equivalent losses which result from deaths due to mental illness, total disability due to mental illness, and the loss of productive time to those individuals * * *" Moreover, such costs do not reflect "all losses associated with partial disabilities, with pain and suffering not fully reflected by lost earnings, with homicides in the populaton not treated for mental illness, and with the excess death incidence among those who have a history of mental illness but received no care."

Indeed, NIMH notes that the cost might well have doubled—to $40 billion in 1974 alone, had such above-mentioned factors been included.

I want to emphasize that we are speaking of mental illness, rather than the health/happiness/achievement of potential/social welfare continuum. We are speaking of treatments as aggressive as many lifesaving physical health care techniques, not programs which seek to expand consciousness or raise the awareness of the general public.

The President's Commission on Mental Health cited, in one of its recommendations, the basic underpinnings necessary in providing insurance benefits for those suffering from mental illness, whether under medicare or any other federally developed catastrophic or comprehensive national health insurance pro-

[1] See appendix, item 3, page 156.

gram. It stated that: "There should be minimal patient-borne cost sharing for emergency care. In all other instances, patient-borne cost sharing, through copayments and deductibles for evaluation, diagnosis and short-term therapy, should be no greater than for a comparable course of physical illness."

Moreover, the Task Panel on Cost and Finance of Mental Health of the President's Commission specifically noted that the financing of other medical services, and this discrimination against mental health services is serving as a barrier to access to care." The panel concurred in the appropriateness and importance of parity of funding and agreed that the funding of services should be independent of whether the diagnosis had been for a mental or physical condition.

In 1971, the American Psychiatric Association Task Force on Aging, established to report on critical mental health issues identified by the 1971 White House Conference on Aging, pointed out that progress made during the previous two decades had been minimal. Among the reasons cited were the growth in number of the aging population, the recognition that their diversified needs may require diversified services, and that medicare did not provide sufficient benefits to allow adequate reimbursement for the treatment of nervous, mental, or emotional disorders. In "Aging and Mental Health," Dr. Robert Butler pointed out that: "Medicare coverage for psychiatric disorders is unrealistically limited and was inserted as a kind of afterthought * * * The system obviously affords inadequate coverage."

Such an approach is penny-wise and pound-foolish not only for the reasons I have already articulated with respect to the lost benefits to society, but also because data have been and are continuing to be amassed which indicate that the provision of treatment for mental disorders can have a cost savings effect upon overall health care costs.

A recent paper, "Mental Health Services and Medical Utilization," noted that the likely influence of psychotherapy on the reduction of medical utilization may be in the magnitude of 14 percent. Other studies which bear out such a prediction include:

(1) Group Health Association of Washington indicated that patients treated by mental health providers reduced their nonpsychiatric physician usage within the HMO by 30.7 percent in the year after referral for mental health care compared to the previous year. Use of laboratory and X-ray services declined by 29.8 percent.

(2) Kaiser Plan in California estimated that the subsequent savings for each patient receiving psychiatric treatment were on the order of $250 per year.

(3) Blue Cross of Western Pennsylvania assessed the medical/surgical utilization of a group of subscribers who used a psychotherapy outpatient benefit in community mental health centers with a comparison group of subscribers for whom such services were not made available. The findings showed that the medical/surgical utilization rate was reduced significantly for the group which used the psychiatric benefits. The monthly cost per patient for medical services was more than halved—dropping from $16.47 to $7.06.

(4) In Texas, a longitudinal study (1973–77) demonstrated that access to needed treatment for mental illness resulted in a reduction in mean length of stay of over-65 patients in inpatient facilities from 111 days to 53 days. This halving of hospital stays resulted in a cost reduction of more than $1.1 million.

Thus, the provision of treatment to the mentally ill elderly has a positive cost benefit—since cost is of such tremendous concern to Congress, and indeed the Nation today. It will enable the elderly not only to receive the care they need, but will enable most of those diagnosed as mentally ill to return to active participation in the social and economic activities of our society.

WHAT IS NEEDED

While I have painted a bleak picture of what exists today in the area of treatment for the mentally ill elderly, I do not want to leave the impression that such picture is not changing. Indeed, we have come a long way over the past 20 years. However, there are a number of major areas in which we may strive for improvement if we are to assure appropriate care for the mentally ill elderly. They include developing an integrated system of care, ranging from independent living to intensive care and treatment programs tailored to the special social and environmental needs of the elderly, with the outreach mechanisms to assure that those in need of services receive care; restructuring our existing reimbursement system to assure that access to treatment for mental illness is possible; continuing our educational process to assure that the concepts of ageism and the stigma

of mental illness do not bar many members of our society from continuing to be, or becoming, contributing members of society; and assuring that adequate numbers of well-trained psychiatrists and other physicians as well as other mental health professionals and paraprofessionals are available to meet the very special needs of our Nation's mentally ill elderly.

I do believe that many of the programs envisioned in the Mental Health Systems Act, now awaiting consideration by the Senate provide some hope for the establishment of an integrated system of care. I am particularly mindful of the two grant categories, one for the chronically mentally ill and one for the elderly, and the efforts contained in each to assure differential diagnosis of physical and emotional disorders, to establish treatment plans which may follow a patient from inpatient to outpatient care. I should point out that we are not speaking of an either-or situation. Patients are not necessarily easily categorizable as chronic or elderly, but may be both, and we should be mindful of the special needs of each population.

I am equally gratified by the provisions which attempt to assure that linkages are made with the existing aging network of social service programs. I am, however, concerned that many of the items within the grant program are optional, not mandatory, and that we could find ourselves continuing to fragment the service delivery system. I find few, if any, ties required to social service programs which assure other of life's necessities such as housing and food.

One way in which such problems with the MHSA might be overcome is to assure the development of clearly defined policymaking responsibilities at both the State and local levels. Such planning could take into consideration the roles of area agencies on aging, departments of mental health, HSA's, community mental health centers, other Systems Act grantees, departments of public health housing authorities and the constellation of social service programs at the State and local level already in place and providing care for the elderly.

Some very simple ideas occur which might be tried. They include the establishment of comprehensive screening and evaluation programs at senior centers, outreach and education about mental illness and how to seek help at congregate meal sites.

Another provision in the Systems Act which I find highly positive is the effort to assure appropriately trained personnel in nursing homes and the recognition that there are many elderly mentally ill who reside in such facilities and other intermediate care facilities. I will return to the training issue shortly.

One issue not often thought about in the context of services to the mentally ill elderly is their environment. Here I am not necessarily speaking of the community care-institution continuum, but rather upon the things around us per se. To the extent that community-based care allows an older emotionally disturbed person to maintain his or her own things whereas a nursing home provides a rather sterile environment, the site is important.

As this committee is aware, congregate meal sites serve many purposes, but among the most important is the sensory stimulation it provides a participant—the smell of food, the company of others, the lighting, the variety of stimuli it provides. Our mental health care system for the elderly must be mindful of the effect of the environment, and as we develop a comprehensive system of care, including housing, health care, communication with others, and treatment, we must recognize the special needs of the elderly. Perhaps this underlies my bias toward community-based care wherever possible, since the home environment, far more often than the hospital or other institutional environment, provides many of the environmental stimuli which can help a person toward emotional and physical wellness. I would like to share with the committee an article I recently published on this very issue, and hope you might include it in the hearing record.[1]

At this point, however, I must return to the issue of reimbursement.

If we are to encourage CMHC's and other public and private entities and individuals to join in the establishment of a comprehensive system of treatment for the mentally ill elderly (and a system which could forestall altogether or reduce the severity of onset of mental illness), there will be changes necessary in the reimbursement mechanisms under medicare.

Specifically, I believe medicare must end its discrimination against the treatment of the mentally ill altogether. While H.R. 3990 makes a start in that direction by improving upon the severe limitations on the treatment of mental illness,

[1] See appendix, item 4, page 158.

legislation before the Senate Finance Committee, and introduced by a member of this committee, Senator Heinz, would eliminate the restrictions now imposed on reimbursement for the treatment of mental illness altogether, and would provide reimbursement to CMHC's so they may better respond to the treatment needs of the mentally ill elderly. I commend S. 1289 to your attention as an example of how a major step toward how removing barriers to care of the mentally ill elderly may be accomplished.

But with a service system in place and appropriate reimbursement mechanisms we must have appropriately trained and adequate numbers of psychiatrists, other physicians and other mental health professionals and paraprofessionals to help provide the care to the mentally ill elderly.

Ideally, and I will restrict my discussion to physicians, the training of future geriatric psychiatrists must begin in medical school. During these years, the student must be exposed to the basic sciences of the aging process and the aged. In the clinical years, the student must have the opportunity of evaluating, treating, and following elderly patients from various clinical settings whether it be in the clinic or as an inpatient in an acute hospital or chronic care facility. The student should be required to participate in the medical care of the elderly in various other community settings such as their own homes, adult homes, and senior citizen centers. These various settings outside of the hospital would provide the medical student the early opportunity of learning the vital importance of the community-based approach to the geriatric patient.

To accomplish these goals, medical school faculty must be willing to commit valuable and scarce curriculum time to geriatrics and specifically geriatric psychiatry. Presently, only two U.S. medical schools have required courses in geriatrics.

I am pleased to note in this context, the existence of legislation developed by a member of this committee, Senator Burdick, which would encourage the establishment of geriatric education programs in medical schools. I concur with him that the general practitioner, too, must become educated to the special health care needs of the older person, and would encourage him to consider adding the area of geriatric psychiatry specifically to his proposed legislation.

There have been some recent developments. The Veterans' Administration has established the GREC centers, 12 in number, throughout the country. These centers, however, do not specifically focus on geriatric psychiatry, though many of the programs do have clear psychiatric programs within them.

More can be done. But to do more will require additional financial commitment to, among other things, NIMH manpower training funds. That program has been frozen for 2 years now, and the mandates of the Senate, spearheaded by this committee's chairman, to assure increasing numbers of trained geriatric psychiatrists and other mental health professionals, can only be accomplished by taking the money from other population groups, such as children and minorities. Therefore, I would urge this committee to give serious consideration, either collectively, or as individual members of the Senate, to recommend to the Senate Appropriations Committee additional funding for the training of psychiatrists and other mental health personnel in the field of geriatric psychiatry.

I have made many requests of this committee. I have done so with purpose, for I believe we are at an historic crossroads. We can make the start as envisioned in the Mental Health Systems Act, or we can do nothing. We can recognize that this bill is just a start, or we can delude ourselves with the idea that we have done all we can. I believe in the ability of this committee to accomplish things—just looking at its track record convinces me of this fact. I urge you to assure that the programs to provide for the delivery of badly needed mental health services to the elderly created under the Mental Health Systems Act are viewed as that start, and that if we are to truly serve the treatment needs of the mentally ill elderly, that all too fragile, all too forgotten segment of our aging population, we need to do more, and quickly, and correctly.

Mr. LIPSCOMB. Dr. Weinberg mentioned the documentary that was on public television last night, "Back Wards to Back Streets," and I saw some heads shaking which indicates that some of you had an opportunity to see that documentary last night.

The question, it seemed, in terms of watching that documentary was the existence of good transitional facilities to prevent what has been called the revolving door concept where people go out and then come

back in because they are placed into a more or less hostile environment in the community or one without adequate supports. The question that I would have for both panels, and perhaps we could engender some discussion around this particular issue, is: Is it a question of where we are putting our Federal, State, and local dollars out of the amount of money that is presently available? That is a key in terms of expanding the kind of program that we saw illustrated last night.

Another thing that comes to mind to me is Dade County, which incorporates the city of Miami, has an aging population in excess of some 19 separate States and the trauma that the older population in that particular county must have undergone in the last week with the tragic events we saw transpire down there. We know many of these people are living in a state of siege in some of the urban areas and that probably just exacerbated some of these feelings that they had. I don't know what the fallout would be, but are we doing anything to enhance the opportunities for health or people who get caught up in these kinds of both natural and manmade disasters that we see occur from time to time in this country?

I would say that the floor is open and we would be glad to hear from any member of the panel.

Dr. Kerschner.

Dr. KERSCHNER. The existing catchment area designations don't begin to approach the issue of how do people end up in these facilities without proper assessment. What happens is that everybody becomes a gatekeeper. Physicians, social workers, State police, family, everyone ends up being a gatekeeper. There is no clear indication State by State that what we need are geriatric evaluation centers but geriatric evaluation centers that have some teeth or some muscle in them.

Anyone coming out of a general hospital being sent to a nursing home, should be seen and screened by a team, whether that be a physician or social worker or physical therapy worker, and then go on to an appropriate facility. That type of screening, and data gathering does not exist.

Mr. LIPSCOMB. Dr. Kerschner has given the fact.

The Civil Rights Commission did the study. Could you share with us your opinion of what mechanisms can and should be used to insure that the assessments are accurate? What comes to mind in terms of logic where we say that 10 percent of the population in a certain area is over 65 and decide that 20 percent of the elderly in that area need mental health services? Does the mental health system then justify spending only 2 percent of its resources on older people? Is this an area we should be talking about when we discuss something like assessment?

Dr. FLEMMING. In my judgment we should. It seems to me that our assessments should be at the communty level to a greater extent than they have been up to the present time. I have been very much interested in the various points of view that have been expressed here today. I recognize, along with others, the need for additional investments in research, in training, in the provison of services, but the thing that haunts me is that we right now have community mental health centers. They are in operation throughout the country. We all seem to be in agreement on the fact that if you take a look at the situation in a particular community you are almost sure to arrive at the

conclusion that the community mental health center is not meeting the need of the older persons. We find that they are serving anywhere from 2 to 4 to 5 percent or that 2 to 4 to 5 percent of the total number of persons served are in, let's say, the 65 or older group. We don't need any really indepth surveys in that particular community to know that it means that we are not reaching the many older persons who need the kind of services that could be rendered by a community mental health center.

Also, these communities are within the jurisdiction of area agencies on aging. I have the feeling that an area agency on aging and a community mental health center could get together at the community level and develop an action program for that particular community with the resources that now exist within that particular community. This joint venture could result in the percentage of older persons being served moving up 4 percent to perhaps 6, 7, or 8 percent over a period of a year or two.

It seems to me that if today's generation of older persons is really going to be helped, what we need are action programs at the community level. There is no question in my mind at the present time that older persons are being denied access to some of the resources because of ageism, and because of built-in prejudice against meeting the needs of older persons at that community level. The only way you get at this problem is through an action program at the community level.

I agree that the organizations of older persons can serve a very important role in helping to develop and to implement the kind of an action program that is needed. I think the passing of S. 1177 will help to facilitate the development of communitywide programs of this kind.

Without being pessimistic, I know that no matter how hopeful we may be, it takes time for a legislative proposal to find its way through the Congress; it takes time to develop regulations; and it takes time to implement new legislation. In the meantime, there are older persons out in the community and there are currently some resources available. The problem is how do we link them up with the needed services? I believe that communitywide action programs could help provide this linkage.

Mr. LIPSCOMB. Thank you, Dr. Flemming.

Dr. Klerman and then we will come back to you, Mr. Hutton.

Dr. KLERMAN. I would recommend at the community level to bring in the general health care system, particularly the primary health care system. Although the percentage of the elderly that are coming into community mental health centers is lower than it should be, we do know that the majority of these people are seeing physicians and they are in the health care system.

Now it is likely that because they are being misdiagnosed or mistreated or inadvertently mistreated that they come to general health care physicians, not saying they are displeased but instead saying they have a backache or that their arthritis is worse so that they cannot think clearly. So one set of initiatives that we have undertaken, in addition to facing directly the issue of prejudice and ageism, is to develop a direct linkage between the community mental health centers and the neighborhood and migrant worker programs. However, this has been done on a limited basis.

In addition, we are working with the HRA—the Health Resources Administration—to help develop curricula for primary care, residency, and training of medical students in the diagnosis and treatment of mental health, alcoholism, and drug abuse problems in the aged and to develop continuing education curricula for the staffs of primary health care programs.

So in amplifying on Dr. Flemming's suggestion, I would think that at the community level it would be very useful if there was some combination of efforts by the area agencies on aging, the community mental health centers, the citizens groups and the general health care system so as to improve the quality of diagnosis and treatment.

Mr. LIPSCOMB. Yes; I think Mr. Brandt's statistics a while ago seemed to indicate that.

Another thing it seems to me is that Mr. Perkins kind of hit the nail on the head a while ago when he was having a short discussion on taking the service to the people instead of expecting the people to come in to get the service. I think at least in our experience in going around the country we have seen that these programs where the outreach or the going out to the older people in facilities like the multipurpose senior citizens center or the nutrition sites or these kinds of places not only has an economy of effort associated with it not only in that you have large concentrations of high-risk people in one place but at the same time it does away with, to a certain extent, the aura or stigma of mental health services being provided.

Bill.

Mr. HUTTON. I would like to go back to Dr. Flemming's comment. It is obviously well known, I believe, that the physical and mental health problems are often closely related and it is apparent, therefore, that the mentally ill elderly individual would benefit from increased sensitivity and cooperation between primary care and mental health care providers. This would require that States develop comprehensive service plans while emphasizing the need for local planning of services that are the most needed and of populations groups that are either unserved or underserved. I think that is important.

I guess that is necessary because the current law authorizing direct funding from Washington to community mental health centers really fails to insure that various populations such as the elderly are receiving sufficient services. But when it gets down to organizations such as the area agencies on aging I believe they are limited because they serve only the elderly. Remember, we have a whole community to serve. While I think that they may be extremely helpful, Dr. Flemming, in determining which services are available in the community, I would prefer very definitely that the management and development of the community mental health care system would be in the hands of the general health care services.

Dr. FLEMMING. I agree with you completely. What I am thinking of, Bill, is the development of an action program designed to build bridges between the older persons and the services that are available. Definitely the responsibility should be just where you indicate, but area agencies on aging can be effective advocates and can help to build bridges that will insure linkages between the older person and the available services.

Mr. HUTTON. I see the advocacy role for the area agencies.

Dr. FLEMMING. Yes; for example, where the advocates sense resistance on the part of those who are delivering service to serving older persons, where they sense discrimination on the basis of age, they can join issue and go to court, if necessary. After all, there is now basis for going to court on the basis of age discrimination. I would like to see a case get into the courts before too long under the Age Discrimination Act, and I think the area of mental health might be a good area to test it out.

Mr. HUTTON. Your report has been a great help in that area. I hope that more action will be taken. That is an area where I would love to see action.

Mr. LIPSCOMB. Dr. Ewalt.

Dr. EWALT. I think the Veterans' Administration is a little more tightly controlled group and has been able to demonstrate the control of discrimination. We have an extended care service and they operate a nursing homes' program and community care programs. They operate the community care homes at various levels of care. One thing that has been found is, if you send persons out there and you don't have any planned program, they tend to relapse and come back. Some of these misdiagnosed cases continue to get worse and worse.

We have found that if you can get them into community-based activities like work programs, rehabilitation, and geriatric day treatment centers in which a patient stays in his community and comes back to the hospital daily—he may come every day, he may come once a week—each one has his own program because you have to individualize the program. Dr. Weinberg said we are not dealing with statistics, we are supposed to be dealing with human beings, and they all differ a little. I think you need a variety of network services if you are going to make a rehabilitation program work. I would plead that we emphasize, all through this, the necessity for individual planning and assesment of each case.

Mr. LIPSCOMB. Dr. Cohen.

Dr. COHEN. Thank you.

I would like to address your last comments, but also your initial question about how one grapples with the difficult decision on where to focus resources. In the context of this hearing, looking at barriers, I think it would be useful to expand on the number of issues that are involved here and to look at any community-based program, such as a community mental health center, with attention to the range of difficulties that it experiences because of barriers, and in a broader sense, the range of difficulties that the Nation as a whole experiences in this regard.

We are also struggling with the issue of to what extent we focus on statistics, as in the example just mentioned with reference to the individual. We have, for example, the very serious problems with institutionalized persons. At the same time we know that this group comprises 5 percent of the older population as opposed to the 95 percent community population. How does one come to terms with how to balance resources for those two groups? How does a mental health service program make a decision on whether to focus its services in an indirect way on consultation as opposed to direct services, such as in the direct treatment of depression? Moreover, in reviewing a range of treatment

options, we must question our research base in terms of available know-how that can be brought to bear on a continuum of problems.

With regard to the issue of the percentages served, whether it is a community mental health center, another clinic, or even a private practitioner's office, to what extent do problems or shortcomings in the approaches to service delivery on the part of providers interfere with adequate care; to what extent are there problems with the older person getting to those services, whether the problem is one of physical mobility, feeling of embarrassment, inadequate resources to pay for care, and so forth?

Then one has the very difficult decision of determining to what extent the service programs should be facility based as opposed to, or in addition to, what extent they are outreach focused, and here we have an increasing number of experiences to point out how much greater the utilization of mental health services by the elderly is when the services are more readily accessible. This is an area which raises cost issues when you are talking about developing a very high powered outreach program or program with home visits. While this is a very difficult and often expensive decision, at the same time we recognize it is an essential one. I think as we look at the different dichotomies of choices we become even more impressed with the very great magnitude of the problem.

Mr. LIPSCOMB. Mr. Perkins, do you wish to comment?

Mr. PERKINS. Yes; I would like to address the 4 percent which continues to be brought up in regard to the studies that were made and presented in the 25 percent that was in the President's Commission report, and I am not sure where all these figures came from.

Public Law 94-63 was passed to provide specialized services to the elderly in 1975. That is when a lot of these figures came out. The community mental health services across the country were required, again by Public Law 94-63, to provide these services without additional funds. At that time we were only required to provide five services, and many more services were added to us, but no additional funds were brought in.

Now you know we can talk about things, but in rural America where professional service is limited to begin with—and we seem to be all things to all people in the community mental health center any more—we certainly have to take the money into consideration. When patients have been deinstitutionalized, in many States they found it to be very successful because there has been a lot of planning that has gone into the community mental health center programs, but the money has not followed the patient to the community; it has stayed with the institutions and, in most cases, the institutional budgets have continued to rise and the community budgets have continued to decline.

As I said earlier, and I feel even stronger about this now than I did a year ago, I think we in community mental health centers are going to have to change our approach entirely to the treatment of the mentally ill, not only the elderly mentally ill, but the mentally ill in general. We have to look at productivity in order to generate funds. We can talk about the discrimination of medicare and title XX. As we know, recent cuts in taxes on title XX have cut out all social services for the elderly in community mental health centers. It

seems that when budget constraints are imposed upon States, some of the first funds that are cut are those for the mentally ill, and it certainly affects the elderly.

I think that in response to the senior citizen centers or the nutritional sites, I firmly agree that this is an effort that we, as community mental health centers, can work together with the nutritional sites. Across the country we have just not been accepted very well by some of the nutritional sites where people do come in in the socialization centers. We have not been accepted by these people. I think we, as community mental health centers, are asking for advice from whomever, to tell us how we, as community mental health centers, can better utilize our staff and our services into these socialization centers or the nutritional sites as we refer to them by the area agencies on aging.

Senator PRYOR. Do you think one of the reasons you are not accepted is because you come bearing the flag under the banner of mental health and this might present a stigma situation for an average elderly citizen who grew up believing that somehow or another to seek mental health services was degrading or something that they would only do late at night or something like that?

Mr. PERKINS. I think you are right. The stigma among the elderly at this time relates to my 84-year-old father in that respect. Certainly there is a stigma of mental illness among the elderly. I think it is something we have to work harder on. I think we can do some of this through the socialization centers, the nutrition site and places where the elderly do congregate. I think that our generation—when I say our generation, my generation—I do not believe we will have the stigma of mental illness when I reach the age of 65 and older as maybe we do have today.

Dr. KERSCHNER. One of the issues that has not come up today is the variance by race and ethnic origin. I know that from my experience at USC that it was very difficult to get minority groups to come in for counseling in the community mental health center. For some reason elderly Jews—I blame it on Jewish mothers—were more willing to come into the facilities but to get Spanish-speaking, to get blacks, to get other elderly to come in for counseling is very difficult. We have to come up with guises other than calling it mental health or counseling in order to get them. I think more research needs to be done on how to attract the minority mentally ill older person to the service.

Mr. HUTTON. Mr. Chairman, in fact Dr. Flemming in his Commission on Civil Rights reported in 1979 that in the climate of scarce resources the administrators had to assign a low priority to outreach and education activities. Now I believe that these activities, this whole question of reaching people, is essential to the development of linkages needed for a comprehensive system of community health services and we would urge the fullest possible authorization for community mental health programs in conjunction with a firm mandate to devote a significant portion of these resources toward consultation and education.

Senator PRYOR. Thank you.

Dr. SHARFSTEIN. I thought that I might just share with you my own company experience which I think emphasizes a number of points here. I have not always been a bureaucrat. About 7 years ago I worked as a doctor and a community psychiatrist in a program Dr. Ewalt super-

vised and it was very clear in this program, which was both primary health and mental health, that there was some underutilization of services by the elderly. So one of the things I did was develop a routine practice of home visits in which I went into the homes of the elderly with my black bag as a primary care practitioner to do physical examinations. I began a discussion with them, got a sense of what was happening with a large number of isolated people, began to get involved in essentially a resocialization center. It was destigmatized. They would not come if I announced that I was a psychiatrist, and I was there to examine their mental status but was there as a general doctor which they appreciated, and then in the context of a discussion some of the issues that they were struggling with come out, and we were able to increase our utilization of services for the elderly dramatically.

The other thing was I was also a consultant in eight private nursing homes in Boston. What was most striking was in my work as a psychiatrist I was to take patients off of tranquilizers. Many of these patients who were in the nursing homes were overmedicated by the general practitioners in the area to try to keep them quiet. It was a very instructive experience for me and I think instructive in terms of the whole issue of not only appropriate placement but appropriate medical care in nursing homes.

Senator PRYOR. You cannot go to visit all of these elderly patients in their own homes or nursing homes, and so forth, but I think that you are the third panelist this morning that has mentioned the utilization of elderly helping to look after the elderly. Did you do some work in that particular field, utilize the peer groups to visit with the elderly?

Dr. SHARFSTEIN. Yes; we worked with a number of groups. One of the most important self-help groups in the Boston area was the widow-to-widow program and in the context of recent bereavement there was active outreach and group counseling in this area.

Senator PRYOR. Would the medical associations object? In this area maybe I am on thin ice with this question. Do they object to paraprofessionals in this particular arena?

Dr. SHARFSTEIN. Well, there is often a question of how much appropriate medical care is necessary. Sometimes you get problems with the local medical society but it has been my experience when people have problems they will advise individuals in the self-help group to seek medical attention and most of the experience with self-help in fact has been to help uncover diagnosable and treatable conditions and move people more appropriately into the medical care system.

Mr. HUTTON. Mr. Chairman, I wonder if I can just add a word in that area. In the senior aides program, the National Council of Senior Citizens operates in 129 different cities. We have quite a number of senior aides who handle local assistance in this way. We also have some who are in State institutions working as aides to help older people when they are sick. They take them to the general hospitals, stay with them and come back with them. I remember a hearing which we had in St. Louis just a couple of years ago over which your colleague, Senator Eagleton, presided and at that hearing one of these aides was asked by the Senator what particular training she had. She was a woman of 65 years of age. She had made herself very proficient at reaching these poor elderly people who were her peers, who

were confused, who were not able to articulate their problems and with whom the doctors had a great deal of trouble—the younger doctors had trouble getting through to them. She said: "Well, they may be confused, I guess they are, but I had a steady training in that. You see, for 20 years I was a barmaid in New York." [Laughter.]

The situation is very clear. You will get opposition on the grounds of the background and training. I remember when we first started health insurance we had the advisory council to advise the Secretary on medicare. We had a whole slew of complaints from the medical associations and everyone said we could not use home health aides unless they have a high school education, they had to be able to do some math, they had to fill out forms. Well, what good was wonderful handwriting when their only real requirement was could they make or not make hot chicken soup. These are the things that we have to contend with.

Senator PRYOR. Thank you.

Mr. Brandt.

Mr. BRANDT. Yes, sir, I don't want to downgrade the importance of institutions and organizations or the need for tremendous sums of appropriations to help out but it seems to me that an awful lot can be done informally. I should not say disorganizedly but unorganizedly in the community. Dr. Weinberg mentioned that each community has its own level of tolerance for bizarre behavior and so forth. You cannot dump people in there and expect the community to accept them unless you know just what that tolerance level is.

A few years ago I testified before Dr. Flemming's commission and I was bragging about our mental health center using aides to go out and look for the older folks and to bring them in. Dr. Flemming said, "What age were they?" Well, they were kids relatively. The elderly do certainly have a role in this and your volunteer organizations and your professional associations can all work together, it seems to me, to educate your communities to what their problems are and what their needs are and bring in the older Americans as part of that educating process. That is about it.

If I may add one little thing. On this stigma thing, I had a cousin and when I was in college he was in high school. He went to what we called the insane asylum at the age of 20 and he died there at the age of 55. In the 35 years whenever I would visit back in Chicago and see his family and his relatives I would say, "Well, how is Ellis?" "Oh, he is still out there"—whispering, "He is still there." Never was that poor boy's name mentioned out loud in the 35 years he was there. Now I hope, as Mr. Perkins, this young generation here will come along and do away with that. That is one of the things that volunteer groups can do. You don't need more money to help beat stigma and help involve the elderly people.

Senator PRYOR. I am afraid that our friends in the real professional categories over here are picking up some of the more practical aspects of what is going on out in the country. Some cooperative efforts are what I consider to be some of the very creative innovations that are being utilized out in the States and out in the communities across the country and I hope that you are picking up on this.

I believe, Dr. Klerman, you had a statement.

Dr. KLERMAN. A number of very valuable suggestions have come

up today and some of them involve legislation. We are very pleased with the support for the Mental Health Systems Act. With regard to changes in medicare provisions that have passed the House and are now before the Senate, we have been told by the staff of the Senate Finance Committee that they have received practically no communications from the constituents indicating that there is an interest among the elderly in improved mental health benefits.

Mr. BRANDT. I don't think they read their mail.

Senator PRYOR. I wonder if Jim Noble would want to comment.

Mr. NOBLE. I neglected to indicate that our association, in conjunction with many of the other national mental health organizations, has developed a plan for the chronically mentally ill which we will be making available to HHS and the White House. We could also make it available to this committee. In regards to the discussion that has been taking place, there is not only a problem of ageism, which has been documented but also with discrimination against the mentally ill and especially the chronically mentally ill. In my personal experience, a part of the condition is due to the perceptions of the staff of aging programs toward including mental health components for the elderly. Many times the staff reacts much more stronger in, than the older persons themselves do, to the mention of mental health services.

Senator PRYOR. Thank you very much.

Paul Kerschner, did you have a comment?

Dr. KERSCHNER. No; I will pass.

Senator PRYOR. All right.

Dr. Weinberg, I think that you wanted to make a comment.

Dr. WEINBERG. Yes, indeed. Thank you, Senator Pryor.

Two things. One, we ought to recognize that the elderly are not the ones who suddenly come up on the scene, they have been here for many, many centuries and have told us a great deal about themselves which we did not listen to simply because it was not a laboratory-type of experience that they were telling us but each one was unique.

I would like to also indicate that we talk about deinstitutionalization and placing people into the community, and historically that is not a new baby at all. I would like to read one paragraph for you from an 1855 article by Dr. John M. Galt. He was superintendent of the Eastern Lunatic Asylum in Williamsburg, Va., and he wrote an article called The Farm of St. Anne published by the American Journal of Insanity, which is now the American Journal of Psychiatry. [Laughter.] I wonder what it taught—what that means. He outlined his plan, and I quote:

> A farmer and his family to reside in a central house suitable for the accommodation of his own household, and some lunatics. The mass of these patients are intended to be workingmen—those of quiet demeanor—laboring under chronic insanity. These will spend a happier life than in the crowded wards of an asylum, and also a more useful one, tending by their work to be self-supporting. * * * By the arrangement which we propose there is obtained the action of the family circle * * * and this arrangement, by more decidedly calling into play the undiseased faculties than occurs in an asylum, would tend in a greater degree to a restoration of sanity.

I would like to make this article part of the record.[1]

What he was suggesting was that we place people from the State hospital into various farmers' homes. In 1940 I started that. It is a pity

[1] See appendix, item 5, page 161.

that Senator Percy is not here, but he knows about it. I started the foster home placement of psychotics into the community. I want to underline it was foster home placement and we did case by case. We placed a psychotic epileptic with a farmer and it worked out so well that the farmer came to me 6 months later and he said: "Dr. Weinberg, I was an orphan, I was raised by my grandmother. My children don't have a grandmother. Do you have an old lady in the hospital who could come into our home and be a grandmother to our children?"

Now that intrigued me no end. We found an elderly person who was very neat and clean. She had delusions, but never acted on her delusions. She had one fault, she talked all the time. She was very garrulous. I told the farmer about all of that. I said she had one fault, she talked all the time. The farmer's face lit up and he said, "Well, that is the way my grandmother was." So we placed that lady with him and it has worked out very beautifully. It taught us that if you find an emotional climate that is acceptable, you can place these people.

What we do not do now is to place masses of people into certain situations without evaluating them. So when Dr. Ewalt says they evaluate individually those people that they send out to the community to do proper casework, that is what is needed, individualization. The older a person gets, the more individual does he become.

Senator PRYOR. Dr. Weinberg, there are one or two speakers that want to comment. I really appreciated your comments.

I think Bob Benedict has a comment.

Bob, before I recognize you and maybe others that want to say something, I am going to have to go back and vote and I probably, unlike Douglas MacArthur, shall not return, but I will remain over there. Senator Percy is coming in so I am going to let him chair the panels' final moments of our hearing.

Before I go let me thank all of you so much for participating today in this hearing. It is a very unique idea to be able to come under one roof and see those who are out in the field providing the services generally and those who are based in Washington and in our Nation's Capital and in your professional categories understand more of what their concerns are and for the folks out in the field to understand more about the problems that we are facing here in the Nation's Capital. I think it has been a good exchange.

I don't want to in any way cut this off prematurely. As I said, we will have to leave. It has been a very good hearing and I think it is the first of its kind on this subject ever held in Washington and it is most timely inasmuch as the Senate Human Resources Committee is reporting out some legislation. With your efforts and your input we could make this legislation better.

I just would like to say Tuesday night I was in Pinedale, Ark., speaking at the graduation exercises and everything was kind of calm up to the moment when they called out the name of a lady to present her with her high school diploma. She came up and got it and she was 72 years of age. The entire gymnasium just fell in with the cheering and the applause and the respect that they had for this woman. So this is the type of thing that we want to know more about and that these are the types of cases that we hope that we can find out about so that they can continue to inspire us.

We very much appreciate all of you being here.

Senator Percy, I will let you conclude the hearing.

Senator PERCY [presiding]. Thank you.

Following up on Senator Pryor's comments about the tribute paid to the 72-year-old woman who received her high school diploma, I have really been struck by the pedestal on which older people are put almost every place in the world but here and that is why I called the one book I wrote on the subject "Growing Old in the Country of the Young." There is a stigma somehow attached to the aging process. We don't have the reverence and the respect throughout our society for the elderly. In some cases, instead of integrating the elderly into our society and having them live within the local community, among all ages and with family members, they may live in a retirement community or a nursing home.

Could any of you comment on what can be done or whether you think anything should be done to remove the stigma attached to the aging process in the United States and whether or not you are concerned about our tendency to segregate them? Many times there is good reason for it, you provide better care and so forth, but is that a concern?

Dr. KERSCHNER. It has to do with the opportunities that we give to the middle-aged children to allow them and their parents to remain in the community. Unless we begin to provide some financial incentives for younger children—I am talking about middle-aged children now—to provide for their elderly parents who may be dependent mentally or otherwise or to get day care, to get home care, until that happens, and not by dumping them—I think that is one of the great myths, that families are dumping people into nursing homes and community mental health centers. They are taxed to their limit. They say, yes, I want my mother and father in the community mental health center so they can provide the service. That will go a long way to helping the situation.

Senator PERCY. Does anyone else care to comment?

Dr. COHEN. Yes; I think one of the very dramatic elements has been the issue of how younger people have perceived older people. To the extent that young people see many of the illnesses of the elderly as being inevitable with aging they might develop negative ideas about later life and in a defensive way shy away from older people. Fortunately, a number of the worst stereotypes about aging are losing some of their intensity. We no longer hear such catch phrases as, "You cannot trust anybody over 30." I think we have passed that point and I think we are entering into a period where we have a growing number of older people who are presenting very new role models for what aging can be, a much more positive image. To the extent that a diversity of programs can be focused on helping older people realize the potential that they can achieve, I think that this will take us a giant step forward and create a better image for younger people to think about what their own old age will be.

Dr. KLERMAN. I will have to excuse myself for another commitment with your permission. I want to express my appreciation for the opportunity and say that it might be useful to follow this up at a future time to see whether some of the suggestions made have been implemented, if some of the deficiencies have been improved upon, and whether some of our efforts in the Federal sector and executive branch

are bearing the fruit that we hope. I request your understanding that I have to leave.

Senator PERCY. Thank you very kindly.

Dr. EWALT. I understood the meeting would be over at 12. I have a 1 o'clock appointment.

Senator PERCY. Just as we have to come and go with these votes, feel free to leave as you have to. I have a couple of questions and if a few of you can remain I would appreciate it. Any of you that have to go, I would certainly excuse you and thank you again for your presence.

Dr. Bernice Neugarten, of Chicago, has suggested that we provide special health or social services for people who need them, no matter what their age. She seems to feel that we are too inclined toward emphasizing just age; you are old, therefore you need these services. She feels the services ought to be provided on the basis of need, regardless of age.

NowI must say that this approach overlooks somewhat the realities of the most effective and powerful lobby we have in Washington. I think the aging lobby is an extraordinarily good one and I use that term in the best sense. They are extraordinarily helpful to us but they are also persistent in the way they go about their lobbying. Could you comment on Dr. Neugarten's feeling that whatever the age, the need ought to be met?

Mr. HUTTON. Dr. Neugarten is saying something which has disturbed most of the aging groups. It is not that we feel that younger people or middle-aged people are not also being discriminated against. But it is the elderly in this country who are being discriminated against with regard to mental health, and not just mental health but many other things. Therefore, we feel that we have to emphasize where this thing is happening to us; where real discrimination and neglect are occurring. Obviously groups such as ours and others in aging have a right and a responsibility to bring them forward.

Now I know that as a gerontologist she is interested in all people growing old. But the fact is that in so many, many cases but for the elderly's fighting desperately, we would not have had even the gains that we have now. We would not have had medicare unless we had an organized fight which carried on for 7 years and which we carried that program on the backs of older people. We would not really have had the major program now which is going to title V to provide employment opportunities for the elderly unless we had not fought for it for several years.

I am afraid that it really does not look to the realities of the situation to say, "Well, we should not categorize as we do when we are pushing for programs." Wherever there is discrimination, wherever we feel that somebody has been underserved or unserved, we have a right and a responsibility to push our case.

Senator PERCY. Thank you, Mr. Hutton.

Mr. Sandler.

Mr. SANDLER. As a Nation, we are lacking in providing adequate mental health care for all in need. The President's Commission on Mental Health concluded that virtually in all segments of our society, there is a lack of effective and available mental health services. We do not wish to single out and isolate the elderly, but we can amend medicare and pass new mental health legislation which will be responsive to the needs of the elderly.

We cannot lose our focus on the elderly. Senior citizen groups may very well have an effective lobbying organization here in Washington, but many times the elderly do not have the clout at the State and local levels. Consequently, we here on the national level do have to fight for them and protect their rights.

Senator PERCY. Thank you.

Dr. Kerschner.

Dr. KERSCHNER. I think, Senator, this discussion, and you quoted Bernice Neugarten, the move over the last 1½ years with the articles like "The Graying of the Federal Budget" and the articles in many journals, the elderly are doing better now than belies what the other gentleman has said. In fact, they are coming from a base of severe discrimination, and so forth. I think the discussion, however, needs to be begun.

I think eventually when the elderly are placed in juxtaposition to lack of children, debts, whatever, when the elderly are able to compete on an equal basis for resources—well, I hate to use the word allied health services. I don't think the time is yet. I think the elderly are still severely discriminated against in mental health programs and others, but certainly you put your finger on an issue that is receiving increasing attention nationally.

Senator PERCY. Dr. Flemming.

Dr. FLEMMING. Dr. Neugarten put her emphasis on the delivery of service by underlining the importance of making services available to all our population. Congress has passed programs over the years designed to make services available to all people in this Nation. I think Congress intended those services to be available without regard to age. But for a variety of reasons, those who have had responsibility for the administration of those programs have introduced age as a criterion and the result is that in one type of service after another older persons have been denied access to those services solely because of the fact that they were older persons.

Congress first responded to that type of discrimination in the service area by passing the Older Americans Act. It said, "If that kind of discrimination exists, we will set up some programs that will be earmarked or identified specifically for older persons in order to offset the discrimination that is taking place." Then in 1975, the Congress passed the Age Discrimination Act and said, "From here on out, it is illegal in connection with programs that are financed by the Federal Government to deny access to those programs on the basis of age."

That legislation is sound legislation, but it is going to take a lot of effort to get that legislation implemented in such a way that older persons really reach the place where they are not denied access. What has been under discussion here this morning, in my judgment, is one of the best illustrations of that. Before you came in this morning, Senator Percy, I quoted one witness in a hearing that we held in San Francisco. This witness was under oath, he had an administrative responsibility for the operation of a mental health program, and in response to a question he said:

> Cost benefit is an operational reality. That is because older persons don't have very much more to live and since we have limited resources we will spend it on younger adults or on children.

As long as that kind of an attitude exists, as far as the administrators are concerned, it is going to be absolutely necessary for those

who are representing the older persons to press vigorously for a "fair share." If the witness should repeat that statement at the present time, thanks to the passage of the Age Discrimination Act, he could be taken into court. The Congress responded to a suggestion from the Commission and has established the right for private action in the courts to bring about the enforcement of the act, but the statement that I cited is a good illustration of what we are still up against.

Senator PERCY. Maybe Dr. Weinberg could follow up on that. Could you comment on the fact that only 2 percent of patients under the care of a private psychiatrist are elderly. In your judgment what are the major reasons for this very, very low percentage of elderly patients being seen by private psychiatrists?

Dr. WEINBERG. First I would like to defend a fellow Illinoisan, Bernice Neugarten—not that she needs any defending but rather that I will interpret what she is saying which is the want of a psychiatrist to interpret and to provide the latent consent to the manifest verbalizations of her findings and instead one of the things that she is attempting to do is to bring the elderly into the mainstream of the totality of the life cycle and the way to bring it in is not necessarily to separate them from the ongoing life significance.

However, as Dr. Flemming has so eloquently indicated, there is that particular need not only for the elderly but needful at this point to move and lobby in that direction until the pendulum swings back into a normalization into the center, so there is a need for both types of views.

Why is there such a low number of elderly in private practice? I would say for one thing to take away the entire issue of ageism and the feeling that psychiatrists have difficulty in treating the elderly for many reasons. It was Professor Freud who stated that the elderly are not fit for psychotherapy and for treatment, they have so much that they have lived that to unravel all of that would take a long period of time and by the time we have unraveled all of that they would be ready to leave the Earth in a very civilized fashion. However, it was not long before some psychiatrists rebuked him and indicated the opposite.

I think I said before when you were out that to a great extent they threatened our omnipotence, they threatened the psychiatrist's belief that he can help on the one hand, but more important than that I think is that the question of remuneration, the lack of provision in the medicare, if you will, and other programs to provide for outpatient evaluation and care of these individuals. We place an emphasis on hospitalization but not when they get out there and as soon as that is corrected you would see the percentage increase from 2 percent to the next availability of providing services for that very needful and fragile population.

Mr. HUTTON. You would see a change, Mr. Chairman, even if we changed it from the 50–50 which it now is. If we changed it, as in Senator Heinz' bill, for example to 80–20, you would see that 2 percent go on. The real problem is the money and many of the people who are confused are under the care of relatives who wanted to spend that money on their behalf.

Senator PERCY. Anyone else?

Dr. Cohen.

Dr. COHEN. I was just going to address the earlier question about targeting. I think that the very need and advantages of this hearing illustrate the need of targeting on the elderly, but I also feel in relationship to your early concern the targeting does not necessarily mean that one has to segregate the elderly. I think that this is also one of the concerns involved in mainstreaming, that one can at the same time I feel target programs on aging and move to mainstreaming the elderly in our society. One of the ways we are attempting to address that programmatically, and this relates not only to psychiatrists but to practitioners in general, is to develop better training and educational initiatives. Such efforts affect not only one's knowledge base, but one's attitudes in working with older people.

A simple example is if one is concerned about the lifespan being 72 years of age, does this mean that an elderly person who is 70 has 2 years of life remaining? That is a misinterpretation of longevity data, since by age 65 one is indeed a survivor with a lifespan approaching 20 years and today in America 1 in 2,000 now exceed age 100. That profoundly can alter one's whole view of the elderly.

At NIMH we have a targeted training initiative of establishing a cadre of experts in geriatric psychiatry and in other areas of mental health.

The goal for this cadre is to involve such experts in the training of generalists and primary care providers so that these mainstream practitioners are better equipped and have a better knowledge base of dealing with older people along with younger adults and children. I think that is a way of again having a targeted effort but at the same time the goal of mainstreaming old people in society.

Senator PERCY. Thank you.

I have one last question for Dr. Weinberg. In your testimony, you mentioned a Texas county situation where an outreach information program was put into operation. During a 4-year period, there was a reduction in average length of hospital stay for the over-65 patients from 111 days to 53. That is a substantial decrease. Do you have any other examples like this one—any examples in Illinois, where an outreach program has been equally effective?

Dr. WEINBERG. I think Mr. Perkins had addressed this issue very well just as well as I have and I gave another example in my submitted testimony, a number of examples.

There is not to my knowledge necessarily within the State of Illinois. We are just starting an outreach program from the community trust fund to go to the homes of the elderly, to bring our little black bag into the home and to take a look at the elderly person. Many of them are afraid to go out of their homes, many of them believe that if they go to a clinic or to see a psychiatrist they are going to be put away. We are going to come to the home with the idea of evaluating, providing some type of a management for that situation and at the same time bringing a cadre of people who learn from that experience. So we are attempting that at the Illinois Psychiatric State Institute right now where we have received a grant from the private sector to do that.

Senator PERCY. Thank you very much.

Does anyone else have any last comment they would like to make?

If not, thank you very, very much. We are appreciative of your testimony.

[Whereupon, at 12:35 p.m., the committee adjourned.]

APPENDIX

MATERIAL RELATED TO HEARING

ITEM 1. MEDICARE MENTAL HEALTH DEMONSTRATION SITE SELECTION CRITERIA, SUBMITTED BY DR. GERALD L. KLERMAN[1]

In accordance with the agreement reached on February 4, 1980, by the Assistant Secretary for Health, the Assistant Secretary for Planning and Evaluation, and the Administrator of the Health Care Financing Administration, approximately 45 ambulatory mental health and/or partial hospitalization sites will receive medicare waivers for cost-related reimbursement for mental health services to the elderly and disabled.

On the basis of criteria established by the demonstration management team, 15 sites from each of three categories of facilities have been tentatively selected for participation. The three groups include comprehensive community mental health centers (CMHC's) ; less comprehensive ambulatory mental health clinics; and partial hospitalization facilities for the mentally ill. As a contingency measure, additional facilities have been designated as alternates.

The comprehensive CMHC's chosen for group I of the attached list are all federally funded under the grant provisions of Public Law 94-63 as amended. As such they must provide a comprehensive range of up to 12 mental health services, including as a minimum, the 5 original or basic services, viz. consultation and education, plus inpatient, outpatient, emergency, and partial hospitalization care. Each of the centers is also freestanding; i.e., nonmedicare provider based; licensed by States in which licensing is required; appropriately staffed by psychiatrists and other qualified mental health professions; and documented as a facility providing a high volume of services to the aged (65 years of age or older).

For purposes of more realistic comparisons, group I sites have been further subdivided into centers providing at least 5, but less than 12, essential services, with no officially designated geriatrics program; centers providing at least 5, but less than 12 essential services including a geriatrics program; and centers providing all 12 services.

The representative sites included in group II are all outpatient mental health clinics which provide a high volume of services to the service area. They are freestanding in the sense that they are not medicare provider-based, nor alined with comprehensive CMHC's. None of the group II ambulatory clinics are grantees under Public Law 94-63, as amended. Furthermore, they provide no partial hospitalization services. However, all are licensed by States in which licensing is required, and which meet the site physician supervision standards of Public Law 95-210, the Rural Health Clinic Services Act.

Group III is comprised of sites exclusively providing partial hospitalization for the mentally ill. Like the group II sites, they provide a high volume of services to the service area; are freestanding in the sense that they are not medicare provider-based, nor alined with comprehensive CMHC's as described above; and they are not grantees under Public Law 94-63, as amended. Additionally, they are licensed by States in which licensing is required.

Given the basic criteria as delineated above, the critical factors for site selection were run by computer against the inventory of U.S. Mental Health/Psychiatric Facilities, maintained by the National Institute of Mental Health's Division of Biometry and Epidemiology. Potential selectees were chosen from among those facilities which ranked highest in terms of units of service to the aged, as reported in the inventory, or estimated on the basis of total services utilization.

Additional screening reviews were conducted using the CMHC's grants and services files maintained by the Division of Mental Health Service Programs,

[1] See statement, page 67.

NIMH, to insure the currency of inventory data. Further, lists of potential sites were circulated among the regional offices of the Alcohol, Drug Abuse, and Mental Health Administration for discreet investigation of each of the facilities, including the nongrantees and all alternates. As a result of the cumulative findings, adjustments were made as appropriate.

No sites were solicited directly for detailed information beyond verification of mailing address and directorship—for purposes of invitation by the Department.

GROUP I SITES [1]

Huntsville-Madison County Mental Health Center, 660 Gallatin Street, Huntsville, Ala. 35801; Garry Porrier, Ph. D., director, 205–533–1970.

La Frontera Center, Inc., 1935 South 6th Avenue, Tucson, Ariz. 85713; Dr. Melba Chavez, director, 602–791–9583 or 792–1057.

El Centro CMHC, 972 South Goodrich Street, Los Angeles, Calif. 90022; Ambrose Rodriguez, director, 213–725–1337.

District V Mental Health Center, 1351 24th Avenue, San Francisco, Calif. 94122; Ms. Myri Sikaters, director, 415–681–8080.

Manatee County Community Mental Health Center, Inc., 415 Braden Avenue (P.O. Box 9478), Bradenton, Fla. 33506; Donald J. Hevey, MSW, director, 813–355–2734.

Community Mental Health Center of Escambia County, 1201 West Hernandez Street, Pensacola, Fla. 32501; Morris L. Eaddy, Ph. D., director, 904–433–3081.

Hillsborough Community Mental Health Center, Inc., 5707 North 22d Street, Tampa, Fla. 33610; Jerry J. Fleischaker, M.D., director, 813–237–3914.

West Ros Park CMHC, 26 Central Avenue, Hyde Park, Mass. 02136; Harold L. Goldberg, M.D., director, 617–364–5200.

Range Mental Health Center, Inc., 624 13th Street, South, Virginia, Minn. 55792; Miller A. Friesen, MSW, director, 218–749–2881.

West Central Community Services Center, Inc., 1125 Sixth Street SE., Willmar, Minn. 56201; P. V. Mehmel, Ph. D., director, 612–235–4613.

Dutchess County Community Mental Health Center, 230 North Road, Poughkeepsie, N.Y. 12601; Kenneth M. Glatt, Ph. D., director, 914–485–9700.

Rensselaer County Comprehensive Mental Health Center, 33 Second Street, Troy, N.Y. 12180; Dr. Anthony Armentano, director, 518–271–3374.

Cumberland County Mental Health Center, Owen Drive (P.O. Box 1406), Fayetteville, N.C. 28302; Mr. Billy K. Graham, director, 919–323–0601.

Seattle Mental Health Institute, 1600 East Olive, Seattle, Wash. 98122; Mr. Myron Kowals, director, 206–281–4300.

Spokane Community Mental Health Center, South 107 Division Street, Spokane, Wash. 98202; Mary Higgins, R.N., director, 509–838–4651.

GROUP I ALTERNATE SITES

East Alabama Mental Health Center, 614 Second Avenue (P.O. Box 2426), Opelika, Ala. 36801; Dr. James Walter, director, 205–749–3346.

Northern Arizona Comprehensive Guidance Center, Inc., 611 North Leroux Street, Flagstaff, Ariz. 86001; Mr. Maurice Miller, director, 602–774–7128.

East Oakland Community Mental Health Center, 10 Eastmont Mall, Oakland, Calif. 94605; Mr. Neil Brenden, director, 415–632–4100.

United Social and Mental Health Services CMHC, 51 Westcott Road, Danielson, Conn. 06239; Stephen W. Larcen, director, 203–774–2020.

Northeast Georgia Comprehensive CMHC, 797 Cobb Street, P.O. Box 6067, Athens, Ga. 30604; C. Clifton Dubois, Ph. D., director, 404–542–8890.

Aroostook Mental Health Services, Inc., P.O. Box 492, Fort Fairfield, Maine 04742; Mr. Robert Vickers, director, 207–472–3511.

Salt Lake CMHC, 640B Wilmington Avenue, Salt Lake City, Utah 84106; Eugene D. Chatlin, M.S.W., director, 801–487–8701.

Washington County Mental Health Services, Inc., P.O. Box 647, Montpelier, Vt. 05602; Roger Strauss, Ph. D., director, 802–229–0591.

Region X Mental Health Services, 1602 Gordon Avenue, Charlottesville, Va. 22903; Mr. Robert Lassiter, director, 804–295–2161.

[1] Group I sites are federally funded community mental health centers.

Group II Sites [2]

Family Counsel of Greater New Haven, Inc., 1 State Street, New Haven, Conn. 06511; Mr. William Mecca, executive director, 203-865-1125.

Personal Services Center, 415 West Forsyth Street, P.O. Box 1223, Americus, Ga. 31709; Mr. Neal Fortner, director, 912-928-1235.

Psychiatric Institute, 2650 South California Avenue, Chicago, Ill. 60608; Robert A. Reifman, M.D., director, 312-890-6100.

Sinnissippi Mental Health Center, Sixon-Sterling Freeway, Dixon, Ill. 61021; Lloyd H. Sidwell, ACSW, executive director, 815-284-6611.

Northeast Kansas Mental Health and Guidance Center, 719 North Broadway, Leavenworth, Kans. 66048; Charles S. Kunce, Ph. D., executive director, 913-682-5118.

West Jefferson Mental Health Center, 400 Maple Street, Harvey, La. 70059; Genevieve A. Arneson, M.D., psychiatric director, 504-367-0485.

Geriatrics Screening, Detroit-Wayne Mental Health Board, 1000 Book Building, Detroit, Michigan 48226; Barbara Clark, director, 313-224-2834.

Northern Nebraska Comprehensive Mental Health Center, 109 North 15th Street, Norfolk, Nebraska 68701; Richard A. Sanders, Ph. D., executive director, 402-371-7530.

Jewish Counseling and Service Agency, 161 Millburn Avenue, Millburn, N.J. 07041; Elliott R. Rubin, MSW, executive director, 201-467-3300.

Suffolk County Department of Health Services, Division of Community Mental Health, H. Lee Dennison Building, Hauppauge, N.Y. 11787; Mr. John Ackerman, director, 516-979-2277.

Life Guidance Services, 2200 West Chester Pike, Bromall, Pa. 19008; Peter Izzo, ACSW, director, 215-353-5210.

Fort Bend County Outreach Center, Richmond Professional Building, 1601 Main Street, Box 109, Richmond, Tex. 77469; Norma Bruce, R.N., director, 713-342-6384.

Community Counseling Center, 3117 North Pennsylvania Street, Oklahoma City, Okla. 73112; J. Ronald Cruse, Ph. D., director, 405-236-3574.

Mount Rogers Community Mental Health and Mental Retardation Board, 275 South Fourth Street, Wytheville, Va. 24382; Mr. Jerome Johnson, director, 703-228-2158.

Central Wyoming Counseling Center, 1200 East Third Street, Casper, Wyo. 82601; Mr. Michael Houston, executive director, 307-237-9583.

Group II Alternate Sites

Community Psychiatric Clinic, Inc., 4803 Hampden Lane, Bethesda, Md. 20014; Marjorie Calhoon, Ph. D., acting director, 301-656-5220.

Central Ozark Counseling Center, 602A Elm Street, Rolla, Mo. 65401; Phil Emmons, MSW, director, 314-364-7551.

Jewish Community Services of Long Island, 97-45 Queens Boulevard, Rego Park, N.Y. 11374; George Rothman, CSW, executive director, 212-896-9090.

Family Mental Health Clinic of Westchester Jewish Community Services, 172 South Broadway, White Plains, N.Y. 10605; Mr. Leonard Rohmer, executive director, 914-949-6761.

Milwaukee Culturally Therapeutic Human Services Clinic, 2309 North 36th Street, Milwaukee, Wis.; George Henderson, director, 414-444-7856.

Human Resources Center, 1914 Susquehanna Avenue, Superior, Wis. 54880; Mr. Dale Olson, director, 715-392-8216.

Group III Sites [3]

Cedarstone Psychiatric Institute, 50 Westwind Drive, Route 6, North Little Rock, Ark. 72118; Mr. James Harper, director, 501-771-1500.

Tri-City Day Care Community Program, 365 Main Street, Medford, Mass. 02155; Andrea F. deMars, R.N., director, 617-391-1496.

Eastern Middlesex Mental Health Center, Day Treatment Program, 7 Lincoln Street, Wakefield, Mass. 01880; Edward J. Domit, ACSW, clinic director, 617-246-2010.

---

[2] Group II sites are nonfederally funded outpatient clinics.
[3] Group III sites are nonfederally funded partial hospitalization programs.

Prospect House, Mental Health Association of Essex County, 424 Main Street, East Orange, N.J. 07018; Mrs. Florence Strindberg, director, 201-674-8067.

Stepping Stones Family Service League, 48 Elm Street, Huntington, N.Y. 11743; Jack Consenstein, CSW, program director, 516-421-4881.

The William A. Mitchell Center, 2517 Burnet Avenue, Cincinnati, Ohio 45219; Mrs. Mildred Taylor Smith, executive director, 513-861-4944.

Hill House, 11101 Magnolia Drive, Cleveland, Ohio 44106; Mr. Henry Tanaka, executive director, 216-721-3030.

Mahoning County Transitional Homes, Inc., 278 Broadway, Youngstown, Ohio 44504; Rogert T. White, ACSW, director 216-743-2756.

Options, 219 East King Street, Lancaster, Pa. 17602; Susan C. Blue, ACSW, program director, 717-392-2164.

Oxford House, Mine Road and Hanover Street, P.O. Box 56, New Oxford, Pa. 17350; Mrs. Anita Comp, coordinator, 717-624-7671.

House of Friendship, 801 12th Avenue South, Nashville, Tenn. 37203; Mrs. Joan Moore, ACSW, director, 615-242-3576.

Day Treatment Center, 1314 West Main Street, Richmond, Va. 23220; Sue Roberts, clinic administrator, 804-355-6553.

Day Care Center—Genesis II, Box 12, Highway 64, Marinette, Wis. 54143; Mrs. Elaine Smith, director, 715-735-9478.

Bridgeway House, 615 North Broad Street, Elizabeth, N.J. 07208; Mort Gati, director, 201-355-7200.

ITEM 2. STATEMENT OF THE NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS, SUBMITTED BY PAUL A. KERSCHNER [1]

Mr. Chairman, I am Dr. Paul Kerschner, associate director of the National Retired Teachers Association and the American Association of Retired Persons. Our associations are here today to offer testimony on a problem of increasing importance to our Nation's elderly, the need for appropriate and accessible mental health services. While many groups have a legitimate claim to such services, the magnitude of the mental health problems of the elderly clearly demand special attention.

The focus of our remarks will be on community-based programs, outreach, the coordination of services and linkages. As such, we will offer for the committee's consideration our reactions to Senate bill S. 1177, the Mental Health Systems Act, as ordered reported by the Committee on Labor and Human Resources. However, reimbursement issues will also be discussed in that such concerns are intimately tied to meeting the mental health needs of the elderly and to the effective delivery of services.

Background

The President's Commission on Mental Health, the Department of Health, Education, and Welfare's Task Panel on Mental Health of the Elderly, the House Select Committee on Aging and this committee have all documented that the significant mental health needs of the elderly are not being met by existing service and reimbursement programs. Those over the age of 65 show the highest prevalance of mental disorders and the highest suicide rate. The elderly occupy a full 29 percent of all public mental hospital beds and estimates are that at least two-thirds of our Nation's 1.3 million nursing home residents have significant mental health problems. In fact, 22.3 percent (or 287,600) of these individuals have as a primary diagnosis either a mental disorder or senility without psychosis. Older persons are also more acutely affected by many common emotional problems due in part to their growing physical and sensory incapacities. Yet the National Institute of Mental Health has indicated that approximately 80 percent of our elderly citizens who need assistance this year for emotional disturbances will never be served.

The mental health problems of the elderly are complex and deeply rooted. Senior citizens are often isolated due to low incomes and by the lack of mobility in obtaining existing services. In addition, depression over the death of a loved one, the loss of social status, and the stigma attached to mental illness and

[1] See statement, page 100.

old age compound in a synergistic fashion the mental health problems of the aged. Still, estimates are that only 2 percent of all patients in private psychiatric care and only 4 percent of all persons seen at public outpatient mental health clinics are over the age of 65. Moreover, only 2 percent of all medicare funds go to mental health coverage for the elderly and only 4.1 percent of the fiscal year 1980 budget of the National Institute of Mental Health (NIMH) has a major focus on aging.

Within this context, our associations find the recent trend toward deinstitutionalization disturbing. Whereas this trend is in principle commendable, in practice it provides little benefit to the deinstitutionalized elderly if community support services and trained personnel are not available. In this respect it is interesting to note that the percentage of Americans institutionalized is today essentially the same as in 1950 (approximately 1 percent of our population). While 133,000 elderly persons were in mental institutions in 1969 this figure had dropped dramatically (by 66 percent) to a total of 44,000 inpatients by 1977. Unfortunately, the bulk of these nearly 100,000 aged individuals that were supposedly deinstitutionalized have in fact been transinstitutionalized into nursing homes and boarding houses. Over the past 30 years, while the number of persons in State mental hospitals has decreased by two-thirds, the number in nursing homes has trembled so that today a full 50 percent of the chronically mentally ill are residents of nursing homes and board-and-care homes. Furthermore, when residents of nursing homes are classified by chronic conditions, 25 percent are diagnosed with chronic brain syndrome and 32 percent as senile. Without doubt, moving the elderly patient out of the hospital or even the nursing home and into the community is correct—but only when and where proper treatment and continuing case management services are available.

Age Discrimination in Service Delivery

In assessing the degree of success that community-based programs such as the community mental health centers (CMHC) network have had in meeting the pressing mental health needs of the elderly, we have reached the unavoidable conclusion that the mental health delivery system has and continues to discriminate against the elderly. As we have noted, according to NIMH up to 25 percent of those persons over the age of 65 have mental health problems that interfere severely with their day-to-day functioning. Yet the fact that CMHC's severely underserve the elderly and that this group has the lowest participation rate of any group compared to their representation in the service area population is symptomatic of much broader based age discrimination practiced by mental health professionals in general. Such discrimination has largely been fostered by negative attitudes toward the elderly on the part of such professionals. These attitudes have in turn led to neglect and avoidance of the mentally ill elderly and are a direct result of the perception of many mental health practitioners that older persons possess difficult to treat if not irreversible disorders. Therefore, dealing with this group is seen as depressing, likely to yield little in the way of professional satisfaction and in many ways compound the professional's own fear of aging. In addition, there is a general lack of sensitivity and awareness on the part of mental health professionals to the mental health problems of the aged.

For the most part, this perception is a misperception. The fact that it continues to prevail is largely because most mental health professionals, especially psychiatrists, receive little exposure to the treatment of elderly patients in the course of their training. Specialized and specific training in psychogeriatrics is very limited. This situation has profound implications in light of the special knowledge and diagnostic skills that are necessary to differentiate among several mental conditions that have similar manifestations in elderly individuals, differences in the way the elderly respond to psychotropic drugs, and the intricacies of social support systems that apply to older people.

Moreover, mental illness in the elderly is not irreversible. To the contrary, it has been stated that upwards of 30 percent of those described as senile actually have reversible psychiatric conditions amenable to treatment. Depression, for example, is a most common malady of the elderly and among the most treatable of all mental disorders. Therefore, it is extremely important that the elderly be evaluated by experienced and knowledgable practitioners since such disorders as depression can result in the same kind of confused and disoriented behavior as much more serious conditions such as chronic brain syndrome.

As we have already noted, it is the nursing home and not the public mental hospital that houses the largest number of mentally impaired individuals. The NIMH indicates that while 146,000 patients are in public mental hospitals, over 300,000 patients are residing in nursing homes. This has largely been the result of an expansion of the medicaid program to pay for a large part of nursing home care for the needy and the transfer from State hospitals of large numbers of elderly patients to nursing homes, and at the same time, increasingly restrictive admissions policies for elderly persons on the part of these hospitals. A great many elderly persons with mental disorders (often senility) are now admitted by general practitioners directly to nursing homes with no contact whatsoever with the mental health system. Of even greater concern is that once admitted to a nursing home these patients seldom if ever receive any type of mental health care. Psychiatrists are almost never involved in the care of these patients, either because they are unwilling to come to the home or because psychiatric consultations were never requested. In combination with inadequate community-based programs, what we find is that over 80 percent of all mental health services that the elderly receive are provided by a primary care or general practitioner outside the mental health field. Primary care physicians attending these patients often casually affix a diagnosis of chronic brain syndrome, but almost always as a secondary diagnosis since medicare or medicaid will generally not reimburse for treatment of this condition which is perceived to be nonremittable.

The elderly have not been much more effective in obtaining mental health services through community-based programs. Community mental health centers (CMHC's), though required to establish specialized service programs for the aged, have limited resources and continue to lack trained personnel. And much like other mental health providers, CMHC's seem to have a preference for treating other age groups. In the areas of outreach and prevention, only 5 percent of all CMHC staff hours for consultation and education services went to those over the age of 65 while 36 percent of such hours were devoted to children-oriented activities (1976). In part, this low level of utilization of CMHC services by the elderly is a result of inadequate CMHC outreach efforts. But it is also the product of the stigma aged individuals attach to obtaining mental health services. It is especially difficult for this group to admit to physical or mental frailty and the fact they are growing older.

Our associations believe that at least a partial solution to this problem can be found in reforming the medicare reimbursement system. Medicare reimbursement practices clearly discriminate against the delivery of mental health services, especially in the case of CMHC's which have not even received provider status under medicare. In fact, in many ways the elderly are merely acting like competent consumers in seeking out mental health services in a setting where third-party reimbursement is possible, i.e., from general practitioners, internists, etc. Whereas medicare specifically denies reimbursement for the treatment of senility (or chronic brain syndrome), many States also exclude by law from State mental hospitals persons with senility. While the current reimbursement system has written these people off as requiring custodial care, there is no payment for custodial care.

Equally important is the fact that current reimbursement policy effectively denied access of the mentally ill elderly to outpatient, community-based mental health services. Not only are CMHC's not considered part B providers, but the medicare system retains a discriminatory 50/50 copayment formula and $250 annual limit on payment for outpatient mental health care. In addition, there is also under medicare part A a 190-day lifetime limit for inpatient psychiatric care as a substitute for the spell-of-illness definition employed for physical health care. While such concerns are not the primary focus of this hearing, we nevertheless feel compelled to highlight them as factors directly limiting access on the part of the elderly to community-based mental health services. Our associations have previously proposed and continue to advocate the following medicare reimbursement reforms to address this problem of limited access and low utilization of community-based services:

—Eliminate the discriminatory 50/50 copayment formula for mental health care in favor of the 80/20 copayment formula used for physical health care.

—Eliminate the discriminatory $250 maximum part B payment for outpatient care of nervous, mental, or emotional disorders and replace it with a $1,000 annual ceiling which would be adjusted according to an appropriate index.

—Eliminate the discriminatory 190-day lifetime limit for inpatient psychiatric care.
—Convey medicare provider status to community mental health centers (CMHC's).
—Authorize payment for services performed by qualified clinical psychologists.
—Provide, as in the House reported bill H.R. 3990, for partial hospitalization visits to medicare beneficiaries.

We strongly support these reforms from an equity and cost savings point of view and endorse legislation (H.R. 3990, sections 7 and 21) nearing approval in the House which would effectively provide greater access to outpatient, community-based mental health services for the elderly. We would further hope that the Senate would add these provisions to the Senate Finance bill H.R. 934 (medicare and medicaid reimbursement reform amendments) when this legislation is considered on the floor in the near future. Eliminating these highly discriminatory provisions will lead to greater utilization of less costly outpatient mental health services and erase arbitrary time limits which currently serve to constrain medical judgment. Moreover, such changes in reimbursement policy will, through facilitating access, likely lead to lower program costs in other health care services. Numerous studies have documented the proposition that patients treated by mental health professionals reduced their nonpsychiatric physician usage by up to 30 percent (Group Health Association of Washington, D.C.; Kaiser Health Plan, California). While mental health services represent a small percentage of overall medicare costs, appropriately targeted such expenditures are truly cost effective.

What we propose then is quite simply a process of addressing the severe mental health problems of the aged by building upon existing programs in a stepwise and cost effective manner. The primary care system should continue to be a valuable point of access for the elderly. However, treatment should be by mental health professionals with at least some expertise in aging. The present treatment system often leads to little in the way of actual treatment or therapy and instead places an excessive reliance on medication to mask the symptoms of mental illness. Our associations therefore support legislation which would emphasize, through financial incentives, the importance of medical training in geriatrics. The involvement of psychiatrists, the point of access to the mental health deliver system, is long overdue in this regard. This must be accompanied by aggressive outreach activity to overcome the lack of access to community programs on the part of the elderly and by comprehensive in-home evaluation for those in need of mental health services. Furthermore, in addition to the medicare reimbursement reforms previously cited, broad based case management services must be a part of any community-based delivery system so as to provide an effective referral system and much better coordination of services.

We would also suggest that the Congress consider funding such services through a colocation effort aimed at providing the elderly a range of mental health services in such locales as senior centers and health clinics. While we would not suggest any sort of duplication of the CMHC system, colocation at such nontraditional centers would go a long way toward removing the stigma of mental illness for the elderly and facilitate the delivery of needed mental health services. This approach takes on added significance in light of low utilization of CMHC services by the elderly and the fact that only 50 percent of the Nation falls within a CMHC service area.

Finally, during the course of reauthorizing health manpower legislation the Congress should provide adequate funding and incentives for training physicians, nurses, social workers, and psychologists in geriatrics. At the same time, the Mental Health Systems Act (S. 1177) and other authorizing legislation must tear down the public policy barriers we have noted that are preventing rather than facilitating the coordination of health, mental health, and social services for all groups in our society. In this respect, efforts on the part of the Center for the Study of the Mental Health of the Aging (CSMHA) within NIMH and others to draw together aging and mental health professionals has our full support as does the Center's technical assistance projects which are targeted on developing the CMHC's capacities and capabilities to better serve the elderly.

Our enthusiasm is somewhat tempered, however, by the meager funding such efforts are receiving and our outright skepticism that knowledge acquired can be transferred to all 726 CMHC's nationwide through publications, workshops, and consultation. Of potentially much greater significance in this regard is the provision for linkage grants in the Mental Health Systems Act (S. 1177) that would

tie together health facilities and programs, nursing homes, and mental health facilities and programs. This is where it would be most appropriate to target funding.

Establishing linkages, coordinating the delivery of mental health services, aggressive outreach programs, and reimbursement reform in our view is the foundation upon which to build an effective mental health delivery system for the elderly. As far as the issue of deinstitutionalization is concerned, CHMC's have not had a significant impact on helping individuals to return to the community—though they may have helped reduce initial admissions to State mental hospitals for some chronically ill segments of our population. It appears as though the increased use of psychotropic drugs and other Federal programs (e.g., medicaid) have had a much more direct impact on reducing the population of our mental institutions. In any event, there continues to be a woefully inadequate level of predischarge planning and followup care.

The documented inability of the community mental health centers (CMHC) network to meet the growing mental health needs of older Americans within their local communities is therefore not at all surprising. In a large part, this is the logical result of insufficient third-party reimbursement (i.e., client fees, private insurance, medicare and medicaid). The GAO has reported ("Legislative and Administrative Changes Needed in Community Mental Health Centers Program," HRD–79–38, May 2, 1979) that in 1977 more than one-half of all CMHC's received less than 5 percent of total revenues from any one of these sources. Reimbursement and thus service delivery have not been maximized in part due to poor CMHC planning but also due to barriers beyond the control of most centers. As the GAO notes, catchment areas have often been poorly drawn leading to a duplication of services or an excessively large service delivery area. At the same time there has been a multitude of separate grant mechanisms under current legislation leading to administrative and financial burden. And perhaps most significantly, centers have been required to offer 12 mandated services in every catchment area whether or not they are needed, already adequately supplied by another provider within the catchment area or conveniently accessible just outside the catchment area. This has clearly resulted in some degree of duplication and insufficient service in some areas.

While centers are now allowed to share some services in their area with other providers, centers should be allowed to demonstrate that certain mandated services are not necessary in a particular catchment area. However, delaying the requirement for specialized services for the elderly should not be allowed in areas with average or above average concentrations of aged individuals. Such an assessment of the composition of the service area should also be conditional to the funding of specialized mental health services for priority population groups (the chronically mentally ill) under the Mental Health Systems Act (S. 1177). This prioritization process is especially important in light of Public Law 95–622. This statute extended and reauthorized the CMHC program through September 1980 and in conveying a greater degree of flexibility to centers in (required) service delivery now mandates merely six services in the first 3 years of CHMC program operation (i.e., inpatient care, outpatient care, consultation and education, emergency care, followup care for area resident's released from other mental health facilities, and assistance to the courts and other public agencies). Specialized services to the elderly, no matter what the composition or mental health needs of the residents of the catchment area, are now to be of secondary consideration and added within the first 3 years of center operations.

Given the severe mental health problems of older Americans we believe the CMHC must be called upon to comprehensively assess the service needs of each catchment area and individually prioritize services. Where the mental health needs of the elderly are obviously of broad dimensions, specialized services for this priority population group need to be retained as a mandated service during the first 3 years of operation.

Finally, I wish to reiterate a key point noted earlier. This is, that symptomatic of the institutional bias of our entire health care delivery system, is the fact that CMHC's which are hospital affiliated or which employ full-time psychiatrists or Ph. D. psychologists are in a much better position to maximize public and private third-party reimbursement. Without the reimbursement reforms we have advocated it will be difficult if not impossible to make current programs more responsive to the mental health problems of older Americans.

ANALYSIS AND COMMENTS ON THE MENTAL HEALTH SYSTEMS ACT (S. 1177)

The Mental Health Systems Act (S. 1177), recently ordered reported by the Committee on Labor and Human Resources, has been characterized as an appropriate legislative vehicle to make current programs more responsive to the special mental health problems of older Americans through a targeting of the authorization and appropriations process. Undoubtedly, changes made to the administration's original bill by the Labor and Human Resources Committee have made this goal achievable. In this regard, our Associations support efforts to improve and initiate mental health and support services for chronically mentally ill older Americans as contained in S. 1177. We have the following comments to offer.

First of all, this legislation indicates a realization of the degree to which the chronically mentally ill elderly are underserved by what is typically an uncoordinated array of community-based mental health and support services. However, while psychiatry is cited as a medical shortage specialty, there is no indication of the age discrimination practiced by psychiatrists and other mental health professionals in the delivery of mental health services to the aged.

In fact, we feel that this shortage problem could more aptly be termed a maldistribution or discrimination problem. Of greatest interest and importance to the elderly in this opening statement of purpose is the recognition that skilled and intermediate care facilities are a part of the institution-based mental health service system from which transition to a community-based service system must proceed. Such a transition is important to nursing home residents since at the present time they seldom receive any mental health services or treatment. Appropriate mental health care, though, can only be realized as a result of better screening prior to admission to and discharge from institutions and through aggressive outreach efforts and different diagnosis.

Title I of S. 1177 establishes criteria for each State mental health system. The State mental health agency is to designate mental health service areas (for planning purposes) within or conforming to areas already designated for health planning purposes under title IV of the Public Health Service Act.

We would hope, and fully expect, that such a designation process would incorporate the General Accounting Office (GAO) concerns for CMHC catchment area designation, that is, the nonduplication of services, the size of the service area and the existence of multiple political jurisdictions. We would also suggest that as a part of the State mental health plan (section 104), especially when evaluating the mental health service needs of the elderly, that the States in cooperation with NIMH should be charged with evaluating the mental health service needs of residents of long-term care (LTC) facilities. This would facilitate the identification and prioritization of (special) mental health services needs of the chronically mentally ill in each mental health service area, as required under the mental health operations program (section 105). Another provision, currently a part of section 105, is the requirement that each State program identify measures needed to be taken to coordinate the provision of mental health services and support services. Regarding this provision, we are troubled by the lengthy transition period of 5 years the States will have to assess and screen inpatient populations for inappropriate institutionalization.

We would also like to see a requirement for periodic reassessment of the residents of State mental institutions. Moreover, persons discharged from or in need of placement in mental health facilities need more than to be informed of available community facilities and programs, they need active case management to guarantee access to these adequately funded and adequately staffed community-based programs and facilities. It is our contention that there should be a more formally instituted preadmission and predischarge screening mechanism intimately tied into the case management process, assuring the coordination of services. The enforcement provisions of this title (section 106) seem appropriate.

The heart of this legislation is title II, which conveys to the Secretary of the Department of Health and Human Services (DHHS) the authority to enter into contracts with public and nonprofit entities for the provision of community-based mental health and support services. While our Associations conceptually support the basic thrust of this title, we have some serious reservations.

In providing for services to the chronically mentally ill through contracts with the Secretary, public or nonprofit entities must provide at least one of three

services: (1) Outreach to the mentally ill in inpatient facilities, boarding homes, nursing homes, residential care facilities, and other community settings; (2) case management; and (3) developing community-support services such as alternatives to institutionalization, screening, and supportive living arrangements. We question the wisdom of requiring that only one of these three services be provided. There may be little value, for example, in contracting for the development of case management services or community-support services for elderly individuals in particular in the absence of aggressive outreach activities. At the very least, outreach and case management should be required in anticipation of necessary and supportive reimbursement reforms. As for contracts with a State agency, only one of five services is required. These are: (1) Identifying the chronically mentally ill (outreach); (2) assessing the needs of these individuals; (3) inservice training for mental health services personnel; (4) job placement for employees of public inpatient psychiatric facilities; and (5) coordinating the operations of State agencies and the provision of mental health and support services for the chronically mentally ill.

Again, we feel that the effectiveness of financial support could be severely compromised by limiting State agency efforts to merely one of five very necessary options. Obviously, there are not limitless resources available to meet the significant needs of the chronically mentally ill. However, in light of the relative severity of the mental health needs of older Americans we feel that resources should be targeted on outreach, case management, and inservice training programs for nursing home personnel. We should not lose sight of this final area of priority concern given the increasing tendency to warehouse our mentally infirm elderly in long-term care institutions and the well-documented inadequacy of nursing home personnel to meet the mental health needs of the elderly.

We are pleased to see that the Committee on Labor and Human Resources has incorporated a section (204) within title II for the provision of mental health and support services to the elderly and that any contract under this section must include outreach activities.

Still, we are fearful that the options are again much too large in that only one of five services would be required of public and nonprofit private entities. These options would be: (1) Identifying and assessing the mental health needs of elderly individuals and providing needed services not otherwise being already provided; (2) case management; (3) coordinating the provision of mental health and related support services; (4) providing for mental health services to elderly residents of, and staff training in, nursing homes, boarding homes, senior centers, and ongoing self-help groups; (5) providing differential diagnosis for elderly individuals. We would repeat, that providing mental health services to nursing home residents and inservice training to staff should be a required service under section 204. Indeed, the extent to which all five of these services are needed to open up access and strengthen community-based mental health programs for the elderly only serves to highlight the woefully inadequate funding levels provided for in title II ($400 million in fiscal year 1982). Quite clearly each of these areas of service in combination with effective outreach activity represents a huge undertaking * * * yet one which, based upon presently unmet needs and a history of discriminatory treatment and gross underservice, should nevertheless be initiated. We might also note in passing that many of these service categories are closely related and the successful delivery of services in one area is often contingent upon meaningful outreach, assessment, and case management activity.

Section 206 addresses the need for a reallocation of resources to focus on the prevention of mental illness and the promotion of mental health among priority population groups (i.e., the elderly). In the case of older Americans, support for such educational efforts is particularly important in order to break down the stigma the elderly attach to mental health services and the mental health delivery system. This is especially the case in those areas of the country served by community mental health centers and where it would likely be inappropriate to duplicate services by providing them through such nontraditional settings as senior centers. In furtherance of this goal we would strongly support self-help groups for the elderly because of the greater risk that this group will incur mental illness. Our associations would be most willing to participate in such an effort in that meaningful and timely assistance is oftentimes best provided through peer interaction. We would also hope that CMHC's would take it upon themselves to emphasize this type of activity within their service areas in light of historically low utilization rates by the elderly of CMHC services. We would add that pro-

visions within section 206 to improve the ability of health, social service, and other personnel to identify mental illness and assure appropriate care are commendable and advisable.

To date, public policy deliberations have largely failed to see the importance of linking health facilities and programs, mental health facilities and programs, and nursing homes—the primary residence of our Nation's chronically mentally ill. Therefore, we strongly support section 209 as an initial step in this direction. We hope that contracts to support such linkages will emphasize the delivery of services in long-term care institutions, health clinics, senior centers, and other nontraditional settings (where CMHC's are either inactive or not available) and that sufficient funding will be made available to intiate these linkage activities.

Section 213 explains eligibility requirements for those States seeking to be the exclusive contractor for services under this title. By and large these standards are excellent. In order for the State Agency to be in compliance it will have to: (1) Monitor placement in the community of the chronically mentally ill; (2) administer a program of support and placement services—including case management, prerelease consultation between the mental health facility and community-based service provider and a written treatment and services plan (developed with the participation of the individual); (3) develop a program with minimum standards for regulating multioccupant residences (e.g., boarding homes); (4) improve the skills of personnel involved in providing services to the chronically mentally ill, particularly through inservice training or retraining; and (5) review State policies and programs to eliminate aspects thereof which discriminate against the chronically mentally ill.

Compliance would be furthered through a required annual report to the Secretary on the State program. Yet, if we are to judge the impact of this provision on the elderly the terminology needs to be more precisely defined. There is some doubt as to what is meant by mental health facilities and chronically mentally ill as used in this section. In referring to discharge planning requirements, do mental health facilities include nursing homes (i.e., skilled and intermediate care facilities)? Moreover, do the inservice training requirements also include long-term care facilities? While we would expect that there be required some degree of predischarge planning between nursing homes and CMHC's (or other community-based facilities and programs), we do not know this for sure due to the casual use of terms.

Section 215 describes the application procedure for contracts with the DHHS Secretary. All applications would have to be submitted to the appropriate State mental health agency following review by the local health systems agency (HSA). The State agency would then submit applications to enter into contracts along with its own and local HSA comments and recommendations to the DHHS Secretary. The State agency could omit or modify applications, but the applicant would have direct right of appeal to the Secretary so as to have a particular application considered as originally submitted. We basically support such an approach out of the realization that the lead agency (State mental health agency) must have the primary management function over contracts for services in order to meet its mandated health and mental health planning function. Also, in many respects, the State mental health agency is better informed and better able to judge the mental health services needs and resources of the State. Our support is contingent, though, on the local applicant retaining the opportunity to go directly to the Secretary to appeal an omission or modification of its application for a service contract.

At this point I would note that the criteria for determining compliance (section 218) seems needlessly vague. While we support provisions enabling entities to submit applications directly to the Secretary for the funding of innovative projects of national significance, we would hope that such project activity would give special emphasis to the provision of mental health services in nontraditional settings.

Finally, we are somewhat puzzled by the funding limitations placed on outpatient services and care as well as mental health services for the chronically mentally ill under this title. We believe that a 5-percent floor (fiscal year 1982) for outpatient funding is too low for legislation whose very purpose lies in making community-based programs more responsive and effective to the mental health needs of the chronically mentally ill. Furthermore, funding under this program to provide mental health services to the chronically mentally ill gets off to a dangerously slow start. Only 10 to 20 percent of all title II funds in fiscal year 1982 and no more than 20 to 30 percent by fiscal year 1985 are targeted

on this group. We believe this demonstrates insufficient commitment to vast numbers of mentally ill older Americans who to date have been grossly underserved by our health care system.

Title III of S. 1177 contains a mental health patient's bill of rights. A litany of specific and individual entitlements, this title includes the right to: Appropriate treatment and services supportive of a person's personal liberty; an individualized, written treatment plan with periodic review; participate in planning of mental health treatment; privacy and a humane environment; access to visitors, personal medical records and legal advocates; be informed of one's rights; exercise these rights without reprisals; a grievance procedure; and to referral at discharge. While the patient has the right to freedom from restraint and seclusion, his or her right to general freedom from physical punishment is not clearly stated, nor for that matter is the patient's right to consultation on transfer and during predischarge planning. Merely the right to referral to other providers seems rather inadequate. We also wonder whether the patient has the right to payment for labor rendered the mental health facility.

There is also some degree of confusion concerning what facilities are and are not covered by title III. Whereas inpatient mental hospitals are likely the primary focus, would elderly individuals placed in nursing homes who have some mental disorder or condition as a primary diagnosis be equally protected? We would note in this respect that the elderly are not always diagnosed correctly and that increasingly they are being denied admission to mental health facilities and programs and instead placed in nursing homes without carefully enumerated rights and grievance procedures. Even if elderly mental health patients did receive such rights there is some question as to whether problems of access similar to those that have arisen under the various State nursing home ombudsmen programs would likewise develop with the establishment of the mental health advocacy program (MHAP). Due to this concern and the trend toward transinstitutionalization we fully support the proposed GAO study to examine the performance of various advocacy programs designed to protect the constitutional and statutory rights of priority population groups and make recommendations regarding measures to improve Federal advocacy efforts.

Summary and Recommendations

On balance, we believe that enactment of the Mental Health Systems Act (S. 1177), as revised by the Committee on Labor and Human Resources, should lead to a more effective reallocation of our increasingly scarce health resources while making current mental health programs somewhat more responsive to the mental health problems of older Americans. State health plans would now have to include how the State intends to coordinate and deliver statewide community mental health services and increase access to outpatient treatment for the chronically mentally ill. However, this legislation does little to address the root cause of low utilization of community mental health services by the at-need elderly—age discrimination on the part of mental health professionals. Incentive grants, special project grants, and curriculum development funding—through the health manpower reauthorization process—do hold some hope for making inroads in the training of mental health professionals, especially psychiatrists. Sterotypical attitudes of the aged must be reversed through technical assistance and inservice training in the long-term care setting. Mental health professionals, through the educational process, must be shown the importance and difficulty of correctly diagnosing an elderly patient and the very real possibilities for reversing any number of mental disorders with the proper treatment and care.

Part of the effort to better serve our grossly underserved elderly population must center on comprehensive educational efforts and much needed reimbursement reform. In order to reverse the stigma the elderly attach to obtaining mental health services there should be a multifaceted education campaign incorporating self-help groups. Our associations would be anxious to cooperate with other aging organizations and mental health professionals in such an effort. Yet, without reimbursement reforms in the medicare system such as we have suggested, it will not be possible to make our current mental health programs more responsive to the mounting mental health problems of older Americans. Most important in this respect is that the Congress put an end to discriminatory treatment in the delivery of outpatient mental health services under part B of medicare. There will be little progress made in making community-based mental health programs and facilities more responsive to special problems of the elderly

if we continue to maintain a $250 annual ceiling on outpatient mental health services while denying provider status to community mental health centers. We believe that to remedy this situation the Congress should adopt Senator Heinz bill, S. 1289, the Medicare Mental Illness Non-Discrimination Act, in combination with improvements in medicare coverage for outpatient services included in the 1980 medicare amendments (H.R. 3990) which are presently awaiting full House action.

Increasing medicare beneficiaries access to outpatient mental health services and providing partial hospitalization visits we believe will lead to long-range cost savings due to reduced levels of inpatient hospitalization. To increase access and reverse present trends, community-based mental health professionals must develop an expertise in aging while medicare reimbursement practices for mental health care are put on an equal basis with physical health care.

Research efforts also need to be more carefully targeted and coordinated. Resources need to be reallocated and increased authorizations and appropriations devoted to the study of senile dementia (chronic brain syndrome) and the causes and treatment of depression in the elderly. We support funding levels at least comparable to those recommended by the National Conference on Mental Health and the Elderly (House Select Committee on Aging, 1979), i.e., at least $20 million for the study of senile dementia and $10 million to study depression in the elderly.

Special attention to the unique mental health problems of the elderly is also a necessary component of research efforts and special project grants in the areas of alcoholism and drug abuse. Alcohol misuse among older Americans—often directly associated with factors such as advancing age, decreased tolerance, incompatability with prescribed medications, and increasing life stress—is the second most frequent cause for admitting the elderly to psychiatric facilities (accounting for 16.2 percent of admissions in 1975). Yet older Americans are not being adequately served in existing prevention and treatment programs. Similar problems exist in our drug abuse programs. With the elderly consuming a full 25 percent of all prescription drugs each year, unintentional drug misuse is common. Too often drug interactions and individual metabolic changes in older persons are not taken into account to dosage recommendations which can result in the older patient becoming depressed and/or being incorrectly diagnosed as senile. Legislation passed by the Congress to extend and amend Federal programs to prevent and treat alcohol and drug abuse should help focus public policy on the special problems of the elderly while more appropriately allocating resources for research and special treatment programs (see Public Law 96-180 and Public Law 96-181).

The Mental Health Systems Act (S. 1177) would establish a center for prevention within the National Institute of Mental Health (NIMH) to coordinate prevention policies and programs (section 501). While we support the establishment of such a unit, we believe specific attention and funding should be allocated to research and programs aimed at the mental health problems of the elderly. To repeat, prevention efforts aimed at the elderly can be most successful if there is an appropriate commitment on the part of local, State, and Federal Government. This commitment so far has been lacking.

On balance, our associations support the enactment of S. 1177. However, we have some serious reservations concerning title II (community services). Primarily, we are concerned with the inadequate funding that is to be authorized for a broad array of community services. We believe that there is a need to focus more sharply on priority areas of concern at the expense of a less ambitious range of support services. Limited resources need to be targeted more specifically on special problems of priority population groups. In this respect, the special mental health problems of older Americans stand out in clear relief.

On a different level, we frankly are quite concerned about the need for the elderly to compete for limited funding with other traditionally powerful constituency groups. This structuring of the contracts process may result in only a perpetuation of the present trend of existing programs not serving the growing mental health needs of the elderly. Our associations are also disappointed that special incentives (e.g., tax credits) for self-help and family support systems have not been included within S. 1177. At the same time we believe title III (Bill of Rights) should provide long overdue protection to the institutionalized mental patient and is deserving of broad-based support.

A primary factor behind the lack of responsiveness of current programs to the mental health problems of the elderly is the insufficient flexibility of these

programs. Our Associations therefore view those provisions of S. 1177 that would provide linkages between physical health facilities/programs, mental health facilities/programs, and nursing homes of special significance. Linkages, aggressive outreach efforts, effective case management, and inservice training for nursing home personnel are especially important given the presently accepted practice by general practitioners of admitting elderly patients with mental disorders directly to nursing homes without the patient having any contact with the mental health system.

This disturbing trend is being compounded by the transition of the deinstitutionalization movement into the transinstitutionalization movement. Our nursing homes are not now providing their mentally infirm patients with needed mental health services and this situation will only intensify with the graying of our population and the otherwise rapid expansion of our Nation's nursing home population. Clearly, this has to be the priority concern of our newly emerging mental health care system. At the same time, health manpower reauthorization legislation must be used to counter the pervasive age discrimination now practiced by our physicians, psychiatrists, and other mental health professionals. Incentives need to be established and training programs expanded to draw these professionals into geriatrics. Furthermore, cooperative agreements among CMCH's, area agencies on aging (AAA), nursing homes, and boarding homes are almost nonexistent. The National Institute of Mental Health (NIMH)'s Center for the Study of Mental Health and the Aged (CSMHA) does have a very limited number of pilot programs linking CMHC's and AAA's for the delivery of special mental health services for the elderly. These few programs are funded by the Older Americans Act and title XX of Social Security, therefore resources are limited. We expect that title II of the Mental Health Systems Act (S. 1177) will significantly expand the resources available for such programs and in the process facilitate a much greater degree of interaction between mental health and aging professionals.

Our associations appreciate having this opportunity to express our views on barriers to the effective delivery of mental health services to the elderly and specifically on the Mental Health Systems Act (S. 1177). We look forward to working with the committee in the future toward the goal of making the mental health delivery system more responsive to the needs of older Americans.

ITEM 3. NEWSPAPER ARTICLE, "GERIATRIC PSYCHIATRY IS MUCH ENFEEBLED," FROM THE NEW YORK TIMES, JANUARY 27, 1980, SUBMITTED BY DR. JACK WEINBERG[1]

(By Robin Herman)

Prof. Monica D. Blumenthal, who runs a geriatric psychiatry clinic at the University of Pittsburgh, was enraged over a memorandum she recently received from the Department of Health, Education, and Welfare. The subject was medicare reimbursement for an elderly person's psychiatric care, and the memorandum read, in part: "It is understood that those symptoms attributable to the chronic brain syndrome condition [the scientific name for senility] are not expected to remit and that treatment directed to this end will be ruled noncovered."

"It is a crime," said Professor Blumenthal. "It is not inevitable that our old age bring senility, she explained." But where senility occurs," she argued, "to exclude treatment from medicare coverage is a crime against the elderly."

Professor Blumenthal, joins other physicians and professors in the field of geriatric psychiatry who are outraged over the nation's prejudices toward its 24 million citizens over the age of 65, its lack of treatment programs for the mental illnesses that afflict them, and its reluctance to pay for that treatment.

"The elderly have not been a population that has engaged the interest of the psychologists and psychiatrists, who see them as crocks," said Dr. Robert N. Butler, director of the National Institute on Aging in Bethesda, Md.

"We know now that it is not naturally a part of old age to feel depressed, slide into apathy, or lose one's cognitive capacities," said Professor Blumental, program director of geriatric psychiatry at the Western Psychiatric Institute and Clinic. Physicians generally agree that these problems are hallmarks of illnesses, most of which are amenable to treatment and to cure.

[1] See statement, page 116.

It is estimated that in the United States between 1 and 1.5 million persons are suffering from chronic organic brain syndrome. In any 100 cases of significant senility, according to Dr. Butler, the specific cause in about 50 cases is senile dementia—whose symptoms include memory loss and confusion. At least 20 cases can be attributed to a progressive hardening of the arteries killing brain tissue.

The other 30, says Dr. Butler, involve a hundred different causes: Overdose of medication for such maladies as high blood pressure, metabolic disorders, diabetes—even severe constipation can lead to electrolyte drain, depression, and the public appearance of senility.

Depression remains the most common mental illness among the elderly and a frequent cause of "pseudosenility." To the elderly, depression means more than just feeling "down." Its symptoms can include inability to sleep well, appetite loss and consequent weight loss, slowness of excretory functions, assorted aches and pains, slowness of thought and serious loss of the ability to concentrate. The latter two symptoms may masquerade as senility, but the patient actually is suffering from an affliction that can be treated by counseling and the appropriate use of antidepressants.

GETTING CARE AND PAYING FOR IT

There is no cure yet for senile dementia, but geriatric specialists point to symptomatic and supportive treatment, that can significantly improve the patient's quality of life; biofeedback, for example, or learned techniques of reorienting yourself when lost.

A major difficulty for the elderly mentally ill is getting the care they need and paying for it. Medicare has a severely limited reimbursement policy for mental health care. Participation in medicaid is elective on the part of the States, some of which set low rates or will not treat senile individuals.

"There's been a tendency which I find abhorrent to say that people with senility are not 'really mentally ill,' don't belong in mental hospitals and therefore belong in nursing homes," said Dr. Butler. By defining chronic organic brain syndrome not as a set of diseases but as a set of social conditions, said Dr. Butler, "we have taken senility out of the mainstream of the health care system."

Medicare, which has uniform regulations nationwide, limits reimbursement for inpatient psychiatric treatment to 100 days during a person's lifetime, while the ceiling on outpatient care is $250 per year. Medicare will not cover the costs of psychiatric care for individuals age 21 to 65.

Medicaid policies vary from State to State. New York's policy places no dollar limit on inpatient or outpatient care although cases are subject to utilization review, according to Ralph Pogoda of the New York State Department of Social Services.

By comparison Mississippi, whose entire medicaid program is in serious financial trouble, has a limit of $350 per fiscal year for outpatient psychiatric care or for inpatient care on the psychiatric floor of a private hospital. And Mississippi's State psychiatric hospitals do not participate in medicaid. "Yet they are the only resource for long-term care," said Martin White, assistant director of medical service for the Mississippi Medicaid Commission.

In Pennsylvania persons with "senility" are excluded by law from State mental hospitals, and according to Professor Blumenthal, community mental health centers are specifically enjoined not to offer such patients care. "The current reimbursement system has written these people off as requiring custodial care and there is no payment for custodial care," she said. "We can't keep these elderly people in the hospital so they fall into a great big vacuum."

Many specialists in geriatric psychiatry interpret these exclusions as the determination by a provider, such as medicare, that nothing can be done for the senile elderly. They deplore the decision that care will not be rendered unless there is a "cure on the horizon." "Extend that principle," said Professor Blumenthal, "and we would not cover treatments for people with cancer."

Dr. Butler points out that by excluding the elderly from medical coverage "we are excluding these people as subjects of research." The Census Bureau predicts that in the next 20 years the population of Americans age 65 and over will total nearly 32 million. By that time, says Dr. Butler, "We will have several million people in nursing homes. If we don't learn something more about these conditions of old age, their causes and treatments, how can we afford this? How can we live with it?"

ITEM 4. "ENVIRONMENT, ITS LANGUAGE AND THE AGING," ARTICLE FROM THE JOURNAL OF THE AMERICAN GERIATRICS SOCIETY, SEPTEMBER 1970, BY DR. JACK WEINBERG[1]

Abstract: Aging should be viewed as a slowly emerging developmental phase in the lifespan of the individual. It involves a dual process: (1) Primary aging, which may be considered the normal progression of biological matter toward eventual death, and (2) secondary aging, which is pathological and is a result of environmental deficiencies and stresses imposed upon the organism.

People, regardless of age, relate to their environment only to the degree in which it contains information relevant to them. Environment has a language containing messages that constantly convey information to us. We perceive and decode these messages through our sensory apparatus. Our sensory organs envelop each of us with personal spatial boundaries within which messages may be perceived, and which may differ in dimension and scope for each organ. With aging, our sensory organs undergo changes which limit their capacity to perceive and decode the messages received. In addition there is the psychological dynamism of the exclusion of stimuli, which is a defensive maneuver of our problem-solving self, our ego, when our reservoir of psychic energy is at a low ebb. Yet, culturally we do everything possible to minimize the amount of information carried by these modalities.

Both the aging process and the environment have their particular languages. Improving the communication between them can prevent or reduce the state of reciprocal withdrawal, which is all too common among the aged and enhances the feeling of alienation and despair. A great deal can be done to enrich the environmental information and thus augment the messages carried to the aging organism.

Agedness is not a disease nor is it an acute crisis. For most of us, it is a crisis in slow motion and therefore almost imperceptible in its coming. Just as night does not fall all at once, so is man not young one day and old the very next. In between there is a twilight period during which most may arguably protest that nothing has transpired, nothing has happened. Most of us therefore must forcibly be brought face to face with the realization that we are participants in a phase of our existence to which attention must be paid if life is to continue to be meaningful and agreeable. A person who is not responsive to the ever-changing environment, thinking and techniques of mankind becomes socially, if not biologically, arteriosclerotic. Once in a comfortable and satisfied mood, little movement takes place, and it is only the dead who do not move.

Psychologically speaking, aging is an intensely felt personal experience. Yet its fabric is a colorful kaleidoscope of genetic inheritance, physiological and psychological deficits, socioeconomic vectors, the timelessness of the unconscious, and the personal legend, the secret personal legend as it comes to grips with reality and the universality of the human condition. To some psychiatrists, aging is virtually synonymous with physical deterioration. Others find it difficult to separate physical disability from the effects of prolonged or intense unresolved emotional conflicts. As for me, aging involves a dual process. Biologically, all living matter has a life cycle ending in death. Primary aging is a process of change moving toward the eventual death of the organism. It is accompanied by functional decline. More germane to my discussion, however, is secondary aging. This is a speeding up of the primary process, and is pathological. It is a result of environmental deficiencies and stresses imposed upon the organism at a time when its coping mechanisms are at a low ebb. Primary aging may be called normal senescence; secondary aging is a pathological process.

Nevertheless, aging may involve growth or development of certain functions while structure and other functions decline or involute. Knowledge and skill can grow through experience and training even as physical strength and speed of learning decline. Despite decreased efficiency in sensory, motor, homeostatic, and perceptual functions or responses, there may be gains in certain complex human functions such as judgment and wisdom. An individual may reach his prime despite biological decline and despite the adverse effects of this decline on complex functions. Total functioning will therefore be the balance struck between the amount of decline and the amount and type of experience, skill or learning acquired.

---

[1] See statement, page 116.

Aging, therefore, is one of the developmental phases in the life span of the human being. Developmental in the sense that it is not a static phenomenon which comes at the end of the organism's existence, but rather a fluid state influenced by one's physiology and psychology (with their economies) and the socioeconomic and cultural environments in which one lives. The organism embraces these attitudes, applies them to itself, and reacts accordingly. To be sure, one out of one ages; yet it is the foregoing variables which bring on the aging process at varying rates and in varying ways to different individuals regardless of their chronological age.

Since I postulate that aging is one of the developmental phases in the life-span of the human being, I must also as a psychiatrist help determine the specific traumata of that period. Each phase of the individual's development, in the quest for adequate adaptation, has some aspects which are common to all, yet each phase also has some problems which are unique to it alone. We probably cannot go far amiss if we were to state that the specific trauma of old age is aging. However, a definition of aging almost defies description. One immediately encounters endless philosophical and scientific descriptions of the end-result of aging but not of the process itself. It is no easy task to assess a process even under the most favorable circumstances. It becomes particularly difficult to do so in the area of human behavior, for the human being reacts to stimuli (internal and external), interacts with others about him, and constantly finds himself in a transactional field of infinite possibilities. This calls for observational powers of no mean proportion, and objective recording which may become outmoded at the very moment of transcription. Recognizing all of these difficulties we must nevertheless strive for an evaluation and assessment of the processes attendant upon later life, if not in their entirety at least in some aspects. It is within this context that I should like to address myself to the elderly and how the environment speaks to them.

The Elderly and the Language of Their Environment

People, regardless of age, relate to their environment only to the degree in which it contains information that is relevant to them. Thus in a very real sense, our environment is a language—a language containing messages that constantly convey information to us. We perceive and decode these messages for the most part quite unconsciously, through our senses. Unlike the younger person, however, the elderly person is immediately faced with a serious problem; that is, that his decoding channels—his senses—are no longer functioning at full capacity. Consequently not all the information in his environment registers with him. He may be receiving only partial messages, or in some cases nothing at all. Depending upon the severity of the causes, this can lead to disorientation and disorganization of the older person's social and physical structure.

The sensory organs envelop each individual with personal spatial boundaries, boundaries within which messages may be perceived, and which may differ in dimensions and scope for each organ. Tactile language would therefore be the closest and, unless invited or eagerly yearned for, may be the most encroaching and threatening of all messages received. Thermal, olfactory, aural and visual stimuli in that order, provide ever-increasing spatial territoriality for meaningful messages of increasing complexity to reach the human being, for him to decode, and to give the proper response. Each of these personal spaces may have a "do not trespass" sign, not discernible to others but quite well delineated for the comfort of each organism.

When cultural determinants are added to these biologically determined boundaries, the problem becomes even more complex. Unless invited, encroachment on one's personal space becomes an invasion of one's privacy. Cultural values, biases and practices tend to decrease the allowable areas of intrusion, inhibit the sending out and receiving of messages and thus further thwart the language of communication. The transactional reciprocity between the human organism and its circumambience is a thing of beauty to behold. For ironically enough, as visual and auditory acuity diminish and the environmental language becomes less discernible, the aged themselves join the vast throngs of the invisible and untouchable in our society.

Compounding these difficulties is the factor of the aged person's psychological self. In a previous publication, I have stated that symptoms that arise with aging have a uniqueness characteristic of that period of our life. They indicate that there is a waning of power and they tend to indicate that the organism is trying

to maintain itself by giving up certain powers in order to maintain or preserve others more essential to its unity and survival.

In general, the symptoms that appear in later life may be divided into three categories: exclusion of stimuli, conservation of energy, and regression. It is the first of the three that interests me most, for in it, I see an ego defense quite common in later life, and one which may lend itself to experimental assessment of the aging process.

EXCLUSION OF STIMULI

It is the function of the ego to perceive and integrate internal and external stimuli. Since the aging process curtails the capacity to deal with the multitude of stimuli that clamor for attention in our complex society, the organism begins to exclude them from its awareness. This is true of all sensory stimuli except possibly for those of the olfactory nerve.

The infant also is faced by the same overwhelming stimuli, with little ego development to help it cope with them. However, the very young can take refuge in sleep, to allow for a gradual exposure to the various clamors and their integration. Then, too, infants have the help of supportive figures who are ever ready to supply ego judgment and strength to the struggling new organism. Both of these elements are not available, nor are they acceptable to the aging organism; hence the exclusion.

Though it may be argued by some that the mechanisms of exclusion of stimuli are identical with the familiar mechanisms of denial, it is my feeling that they are quite different. Denial implies that a stimulus has been perceived and cathected, and then cathexisis has been withdrawn. Not so with the exclusion of stimuli; this is an unconscious blocking out of stimuli with an investment of energy only in that which becomes emotionally pertinent and of survival value. The problem is how to assess experimentally the rate and extent of the exclusion of stimuli so as to utilize this mechanism as a psychophysiological measure of aging.

As a result of all the foregoing factors, the elderly rely on quite different sensory information in dealing with the environment. Tactile needs, touch, and the feel of things are a case in point. Chairs and furniture are often pushed up against walls and other relatively stable objects when indoors. Out of doors, the elderly prefer to sit near objects such as walls, trees, bushes or poles, avoiding open spaces that lack such points of reference. They like to finger the fabrics for the sheer pleasure of tactile sensations—the sensual aspects of them—and are repelled by the coldness of smooth plastic fabrics which are designed for durability and sanitation but devoid of pleasant emotional language. Affectional physical contact with the aged is denied them by society. Our physical encounters with them are perfunctory, with no warmth or conviction behind them. And yet there is a psychobiological hunger which usually remains ungratified. The sensory organs of the aged person's skin often become dull, as if in response to an anticipated deprivation. There is no need to feel, if feelings are to be denied.

Visually the older person is more concerned with messages in his environment dealing with movement. Available data suggest that he relies more heavily on visual information channeled through the periphery of the eye, which magnifies movement, than on information received by means of detailed and clear vision. Psychologically it is as if the older person anticipates some external threat to his being and is alert to ward off an offending object, or he is in search of a supportive figure.

As for thermal, olfactory and auditory information, much higher levels of input from the environment are needed by the aged than by the young for adequate interpersonal transactions. Yet we do everything possible to minimize the amount of information carried by these modalities. Deodorants, constant temperature, and uniform acoustical treatment provide a monotony and uniformity to the environment which, while desirable from many viewpoints, deprive the aged of valuable environmental information.

The sensory components underlying environmental messages are somehow analogous to the sounds of language. We are creating environments saturated with visual messages that require the use of detailed and clear vision; environments that are underdeveloped in terms of tactile messages; and environments that almost totally neglect the channel capacities of smell, heat and sound.

Recommendations

The problem now is how to help the aged establish better communication channels with their environment.

By utilizing the aforementioned data, one can plan a much more meaningful environment for the older person.

Thus, the older person's space should be such as to provide him with ample opportunity for tactile experiences. A cluttered, object-filled environment may be far more preferable than sterile neatness and cleanliness. Simplicity, seemingly desirable, may be emotionally quite sterile. Not only do the objects in the old person's immediate environment provide for the needed touch, but they may also be the repository of shared experiences. The more often the aged person loses close friends—others with whom he has shared life experiences—the greater is his need to hold on to inanimate objects with which he has shared common experiences. These objects replace and are substitutes for cherished reunions when very few if any friends are left to meet with and reminisce. Chaotic disorder to the observer, may represent organizing strength to the observed old person.

The surfaces of floors, walls and furniture should be of different textures, to provide the old with tactile information relevant to their lives. These variations also could be augmented by color coding and lighting. A designated space for a sense of privacy and intimacy could thus be established for the individual even in multi-occupancy units in hospitals, nursing homes and homes for the aged.

Variations in smells and sound are yet other ways in which information can be introduced into the environment of the older person. Multiple are the methods and means by which the environment can reach out, "speak" to the elderly, and re-engaged them into the life stream.

ITEM 5. "THE CHRONIC PATIENT: THE STRANGER IN OUR MIDST," ARTICLE FROM HOSPITAL AND COMMUNITY PSYCHIATRY, JANUARY 1978, SUBMITTED BY JACK WEINBERG [1]

The chronic patient is perceived as being foreign or alien, a stranger who either will not or cannot integrate himself into the community's values and expectations. One concept of returning the mentally ill to the community was proposed in 1855; the author describes that system and also a system of foster care and other kinds of community care established in Illinois in the early 1940's. He emphasizes the need for a climate that accepts and is acceptable to chronic patients, and he discusses certain aspects of their care, including the problem that the so-called communities in which they are placed are communities in name only.

Sir Walter Scott, in describing the strange behavior of one of his characters, wrote, "She was a person of odd and peculiar habits, wore a singular dress, and affected wild and solitary haunts." Odd, peculiar, singular, wild, and solitary—all terms suggestive of the emotionally charged and uncomfortably evocative words "strange" or "stranger", and equally applicable to the emotionally ill chronic patient.

Usually a stranger is one who is perceived as being foreign or alien, one separate from the French for *insane* and from the Latin for *to estrange*, is the key word; its roots explained to me, when I first committed myself to psychiatric training, why our state psychiatrist had the peculiar title of state alienist.

Clearly then, when we are dealing with the chronically ill patient, we are dealing with a stranger. He is a stranger who, depending on one's view, either will not or cannot assimilate, will not or cannot integrate himself into the fabric of our lives, into the tapestry of our values, and into communal expectations. He is not happy with the world as it is and is engaged in an effort to transform it. He transforms reality to fit his private feelings, his delusional thinking, and he does so in ways that do not evoke consensus, that more often than not remain strictly and fiercely individualistic, strange, bizarre, uncommunicable, and even destructive to the self and others.

---

[1] See statement, page 116.

Modern psychiatry is accustomed to view psychiatric manifestations not as queer additions to the so-called "normal" personality but as specific aspects of psycho-physiological developments that, in essence, are identical in the normal and in the pathological person. The non-ill person's activities are derived from the patterns that have become the common style of his culture, directed by thinking processes of logical order or what has been described in the psychoanalytic literature as the secondary process.

Not so the activities of the chronically ill person, who calls upon an archaic, obsolete, primitive mental mechanism that is psychodynamically known as the primary process. Thus he interprets reality in a way that appears to us to be irrational, illogical, and delusional.

But then too, we are quite aware that there are realities that transcend the truth. As I have said in another publication. "Paradoxical though this may seem, it is not so to anyone who has heard the words of the emotionally ill . . . the poetry of the anguished mentality which becomes its credo, its reality. The 81-year-old confused and incontinent woman whose delusion is that she is pregnant clings to what is to her a reality despite all objective findings to the contrary. For truth is objective and reality subjective.

"And as long as the latter is true, reality varies with the individual and is clear to anyone willing and able to interpret its meaning. What the old woman was saying was that she harbored, within herself, her own regressed self and was about to deliver it. If senility is the 'second childhood,' then she was pregnant with it and at the point of delivery. Viewed from this perspective, her delusion makes sense—her method of expressing it, poetry." [1]

Even though poetic, the behavior of the sick elderly or the chronically ill is often egregious, strange, and bizarre. May I now state the obvious: that it is we who may seem strange and bizarre to them, conforming to a consensus that is also manmade and therefore quite possibly fallible. We are strangers to one another, wary and untrusting. Add to that the poignant truth that the chronic patient may be alien and strange to himself (and a times painfully aware of that alienation), but that more often than not he is totally absorbed in the romanticized poetic aspects of his other self and responsive to its seductive beckoning.

Lost in his own imagery, the chronic patient is therefore difficult to reach. Nevertheless, well-meaning efforts have been made to alleviate what we believe to be his suffering and to bring him back to the community of his peers. Historically, the reform movement of the 1840's, moral treatment, took mentally ill patients out of the communities and placed them into remote state hospitals. The reform movement of the 1960's has removed mentally ill individuals from remote state hospitals and shifted them to community placements.

Both movements were based on humanitarian motives and buttressed by scientific observations and conviction. Both attempted to make up for the abuses of the alternate approach. Both promised more than they could deliver, but neither was given a fair trial. Both could have delivered much better service to the mentally ill if there had been adequate financial support and humane program planning. Both had to compromise in order to win legislative support by claiming that care in new settings not only could be better but also would cost less rather than raising taxes. It is we, to our regret and our shame, who succumbed to illusory beliefs, denying reality, and thus we failed the mentally ill, our ideals, and our own humanity.

Historically, too, the concept of returning the mentally ill to community life is not new at all. It may be evidenced by a proposal made in 1855 by Dr. John M. Galt, II, superintendent of the Eastern Lunatic Asylum in Williamsburg, Va.

In an article called "The Farm of St. Anne," published in the American Journal of Insanity, he outlined his plan. "A farmer and his family to reside in a central house suitable for the accommodation of his own household, and some lunatics. The mass of these patients are intended to be working-men—those of quiet demeanor—laboring under chronic insanity. These will spend a happier life than in the crowded wards of an asylum, and also a more useful one, tending by their work to be self-supporting. . . . By the arrangement which we propose there is obtained the action of the family circle . . . and this arrangement, by more decidely calling into play the undiseased faculties than occurs in an asylum, would tend in a greater degree to a restoration of sanity." [2]

[1] "On Adding Insight to Injury," Gerontologist, vol. 16, February 1976, part 1, pp. 4–10.
[2] Vol. 11, April 1855, pp. 352–357.

There was outraged opposition to Dr. Galt's suggestion. Nevertheless, in 1885 the board of health of the State of Massachusetts enacted a law that authorized the boarding out of the emotionally ill. "Insane persons of the chronic, quiet class" were to be placed into "suitable families," the cost to be borne by the state for those who were indigent. In the first 20 years of the program, 762 patients, mostly women, were thus placed. Despite the success of the program, Massachusetts was for many years the only state to provide this service. Interest in various forms of community care ebbed and flowed, and it was not until the 1960s that community care of the mentally disabled became a national priority.[3]

COMMUNITY CARE IN THE 1940'S

My own efforts to conceptualize a model for community-based services for mental health, and the implementation of it, date back 36 years. In 1941, convinced as we were in Illinois that a more liberal policy for the release of patients would result in improved psychiatric, humanitarian, and fiscal values, we fashioned a policy that the state's resources should no longer be drawn into the building of additional inpatient units and the provision of new beds but directed instead to an enlarged extramural mental hygiene and supervisory service, a liberal release program, longer and more careful supervision after release, and the establishment of mental hygiene facilities to facilitate the community adjustment of patients who would otherwise be committed to institutions.

Within the year we had established a system of services to cover the entire state—22 traveling clinics under the supervision of the Chicago Community Clinic. The clinics had three primary functions:

To provide aftercare to released patients within their communities over a prolonged period of time, to help rehabilitate them, and to preclude recidivism.

To provide a diagnostic and consultative service for patients about to be committed. The service was used by judges, physicians, social workers, and relatives. If a precommitment study indicated that institutionalization was not required, prescriptions for the vocational, social, and home adjustment of the patient were given. Members of the clinic identified resources in the community, and they also provided information to the community about what the state hospital could or could not do for the different types of personality maladjustment.

To place in foster homes hospitalized patients who had no families or those individuals who could not remain with their families. Within a period of 18 months, 340 patients were removed from the state hospitals and situated with families other than their own.

It was during that time that foster home placement for the aged was serendipitously established. A young epileptic patient whose illness was not controlled by medication was placed with a young farmer and his family who needed help. The arrangement was extremely successful, and after six months the farmer came to the clinic with an interesting request. He said that he was an orphan and had been raised by his grandmother. His children did not have a grandmother (his wife's mother did not live nearby), and he wondered whether we had an elderly patient in the hospital who could come to live with them and be a "grandmother" in the household.

The request intrigued us, and we were able to find a somewhat compulsive elderly lady who was neat, meticulous, and helpful to the nurses; she was delusional but never acted on her delusions, and she was garrulous to distraction. The farmer was informed of all that, including the fact that the lady had one fault: she talked all the time. His face lit up, and he said, "That's the way my grandmother was!"

The arrangement was a great success, and it made me realize that a placement based on careful casework, underscoring the need for an emotional climate that would be acceptive of the elderly, and acceptable to them, would in the long run be a placement of choice for them or for any other human being. It didn't take us long to be able to place quite a number of the chronically ill and elderly in various families. Aftercare was provided for these individuals, and the families who boarded them were assured that they could have access to the clinic if difficulties should arise.

Thus foster care was a modality that was individualized and tailored to the needs of a given person in a given situation. Understanding the uniqueness of the

[3] "A Century of Debate Surrounds Community Care," Hospital and Community Psychiatry, vol. 27, July 1976, p. 490.

reality of each person, the young and the old, is the very essence of psychological skill—skill that must deal not only with individual variance but also with the shifting quality of the human being's subjective state as he grows, develops, and ages.

Each period in the lifespan of man forces on him a different reality, based on altered physiology and on the extent of the richness of the human experience. Each period can be rich, varied, colorful, and in turn enriching; conversely, to many it may be impoverished or empty and serve only to emphasize the futility of life and its meaning.

However, no matter what one's experiences may be, there is a need for an elaboration of the experiences that tend to distort the objective truth but that add to the uniqueness of the reality that the individual wishes to convey. That reality is far more real than the facts, for it delineates more clearly to the observer the actual personality of the observed. What emerges from the distorted experiences is a romanticized version of events, a dramatization of the facts; the good becomes magnificent, and the sad tragic. All of that needs to be understood if proper placement is to be made; obviously it is a time-consuming but not too expensive modality to provide for human dignity and well-being.

THE ABSENCE OF COMMUNITIES

The types of individual placements into foster homes that were made in Illinois in the early 1940's are seldom made today. Large numbers of patients are placed in smaller facilities no less identifiable as institutions than the ones they left. And that step is wrongly identified as community placement—wrongly because, here again, I see problems for the chronically ill. The "communities" into which they are placed are geographic localities that may be candidates to become communities, but that are not communities. They are merely neighborhoods.

This characterization is particularly true of the larger urban areas where many of our poor and sick congregate, and where anxieties about the most elementary aspects of safety and security are great. Added to that situation is the lack of common historical memories and common cultural values that make it possible to establish a network of services based on such common memories and values rather than on monetary rewards or financial feasibility.

An experience in Chicago within the present decade is not unique. Many chronically ill and aged individuals were placed in a number of sheltered-care facilities—converted old hotels and apartment buildings—in Uptown, a neighborhood being resettled by Puerto Ricans recently arrived in the U.S. and by improverished whites from Kentucky and other Southern states. The two groups were strangers to one another and were also beset by enormous problems of resettlement, acculturation, and unemployment.

It was too much to ask this so-called community to integrate a new segment of strangers. Hostilities and resentments did of course arise; they should have been expected. All of the disparate groups were competing for the scarce resources available, and the least served were those who were least organized—the chronically ill and disabled.

Before community placements are made, communities must be prepared, resources must be mobilized, and the tolerance of a given population for the comfortable absorption of the ill and disabled must be determined. We must not merely pay lip service to these policies but must fiercely adhere to them as a sine qua non.

BEYOND ENVIRONMENTAL CHANGES

Let me present one more thought about the chronic patient. The treatment of psychiatric disorders is often difficult or impossible in the absence of an adequate base of combined social and economic support. Conversely, the obviousness of the socioeconomic needs of most of the mentally ill or the disturbed aged may lead to the mistaken belief that situational manipulation alone—whether it be a change in residence, a supplement to funds, or an alteration of family relationships—can yield therapeutic success.

It is true that environmental changes, without intervention by a psychiatrist, may on occasion result in dramatic success. However, it seems that even where environmental changes are indicated and possible, such changes are most likely to be helpful when they are made with psychiatric understanding of the person and his social situation.

I am keenly aware that a malfunctioning biological and social-psychological system, such as man is, may respond to a variety of interventions, not necessarily nor only psychiatric. Many times the disordered behavior never comes to the attention of a mental health professional but is adequately dealt with by a social system in which the concepts of mental health are completely foreign yet are somehow intuitively utilized. That is possible because all mankind shares in the common human condition. Our experiences are qualitatively alike; they differ markedly only quantitatively. However, if situational improvements are made in a routine or mechanical manner, without an understanding of the person's disturbed or disturbing behavior and his emotional needs and expectations, they may fail. They may even compound his disorder and lead to his rapid decline and return to the hospital.

I have touched on but a few of the vexing problems related to the care of the chronically ill, whom we on the whole have neglected. Much needs to be done by all of us, whether in the hospitals or in the communities. We must redress a justifiable grievance on the part of this neglected segment of our population, and we must make a commitment to the chronically ill as well as to the ethical and humane aspects of our respective disciplines that demand of us dedicated service to the totality of the population.

The chronically ill are viewed as unexciting strangers and intruders who divert us from what we view as the more gratifying patient, the young, verbal person who is in an acute episode and who has a family for collateral therapy. We must exercise our imagination and our creativity to respond to the challenge of the chronically ill stranger who is in our midst. We indeed have a great deal of work to do.

ITEM 6, LETTER AND ENCLOSURE FROM ELMA L. GRIESEL, EXECUTIVE DIRECTOR, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM, TO SENATOR DAVID PRYOR, DATED MAY 22, 1980

DEAR SENATOR PRYOR: The National Citizens' Coalition for Nursing Home Reform is a national coalition of 74 citizen/consumer organizations founded to improve the long-term care system and the quality of life for nursing home residents.

The coalition is deeply concerned about the nearly insurmountable barriers to the provision of mental health services to the elderly residents of nursing homes and other adult care facilities. We will limit our comments at this time to pertinent aspects of S. 1177, the Mental Health Systems Act.

Briefly, the increased vulnerability of the aged to the ravages of mental illness are well documented. This vulnerability is exacerbated significantly in the elderly residents of nursing homes and boarding homes; their mental illnesses are often unchecked and untreated. Experts estimate that between 50 and 80 percent of aged residents in nursing homes demonstrate some degree of mental impairment. In fact, a great many of these disturbed residents are former mental patients who have been "dumped" into the community through the deinstitutionalization process with no provisions whatsoever for meeting their desperate need for mental health care.

Furthermore, many of these victims suffer from conditions such as depression and senile dementia, which are often responsive to a variety of therapies, including drug therapy.

Despite these facts, residents of nursing homes and boarding homes almost never receive any form of mental health services. Fewer than 5 percent of nursing homes employ a psychologist; only 25 percent of nursing homes offer the services of a social worker. According to our research, exemplified by the experience of Ms. Reba Zvonik, a nursing home ombudsman for region No. 7 in Arkansas, herself a former nursing home administrator, the majority of adult care homes actively discourage any interaction between needy residents and social service agencies.

Provisions in S. 1177 regarding services to the elderly and the chronically mentally ill represent a step toward addressing the above-mentioned problems. Provisions which are particularly beneficial to the elderly mentally ill residents of nursing homes and boarding homes include:

Application requirements which call for State agency applicants to provide a program of support and placement services for chronically mentally ill patients deinstitutionalized or diverted from State hospitals. Of particular significance

is the provision which requires State applicants to develop a program for regulating multioccupant residences in which chronically mentally ill individuals reside. Inclusion of access by mental health and social services personnel into standards for these homes is a very important contribution toward effectively addressing the neglect of these patients.

The provision that requires all applicants to assign a case manager to deinstitutionalized or diverted patients. This will afford a degree of protection that these individuals need.

Allocation of funds for services to the elderly mentally ill, including provisions for outreach to residents of adult care facilities. Provision of medical differential diagnosis will prove very helpful in treatment.

Development of grants to serve the chronically mentally ill, including provisions for outreach to residents of nursing homes and boarding homes.

However, there are some weaknesses in the bill which should be corrected in order more effectively to meet the needs of the chronically mentally ill and residents of adult care facilities, We strongly recommend the following amendments:

All applicants must provide outreach services to residents of nursing homes, boarding homes and community based other congregate living facilities.

Applicants for special grants must provide assurances that they will provide more than one service.

Annual progress reports must be filed by each applicant at the end of the year to the NIMH for review. The NIMH will evaluate progress in treating the chronically mentally ill and will report its findings to the Department of Health and Human Services and the congressional aging committees.

A higher level of funding is needed in order to meet the goals of the Mental Health Systems Act.

In addition to the above amendments, we recommend that further hearings be scheduled to review the urgent need of residents of nursing homes, boarding homes and other adult care facilities for mental health services.

Thank you for your consideration of our concerns. Please feel free to contact my office for clarification or more information.

Sincerely,

ELMA L. GRIESEL.

Enclosure.

NATIONAL CITIZENS COALITION FOR NURSING HOME REFORM

1980 MEMBERSHIP RESOLUTION

Deinstitutionalized Elderly

Whereas the problems of elderly deinstitutionalized from mental institutions are nationwide,

Whereas a preliminary study by the staff of NCCNHR indicates the seriousness of the problem and the dire consequences in boarding homes,

Therefore, be it resolved that the staff and board of NCCNHR continue the study in depth with a view to finding and recommending positive and satisfactory solutions.

ITEM 7. NEWS RELEASE FROM THE FEEDBACK FOUNDATION, INC., SANTA ANA, CALIF., DATED MAY 22, 1980

Project PACE, a new program sponsored by Feedback Foundation, Inc., is experiencing difficulty. PACE stands for psychological alternative counseling for elders. This new innovative program is attempting to meet the mental health needs of the elderly. PACE is funded through county revenue sharing dollars.

This program was started with seed money. The intent was for a program to find alternative funding sources after the program was started. Unfortunately, the revenue sharing concept has not worked. We have not been able to generate the money needed. If the revenue sharing bill is not renewed and alternative funding sources not found this vital program for seniors will be extinct.

PACE is a mobile counseling team which visits elderly nutrition sites and senior centers in various regions of Orange County. We help seniors deal with depression, alcoholism, suicide, grief, and other problems which may threaten their health and independence. Through the use of individual counseling, group

workshops, family counseling, and referral services, seniors find new ways to cope with their specific problems.

Since the programs inception it has become recognized as an important community resource (Los Angeles Times, August 1979; Senior People's Press, September 1979; Daily Pilot, January 1980; The Register, January, April, 1980, ERA, February 1980). Even with this recognition we have not been able to generate alternative funding. We have sent out requests for funding to 387 private foundations and received 254 rejections. Project PACE has approached the area agency on aging for funding but was denied the request. We have also asked HSA for funding but were rejected due to lack of mental health funds. We have explored the possibility of funding with Senator Hayakawa, Senator Cranston, and the Department of Mental Health, Sacramento. This effort received nothing positive.

The question I pose to the reader is where does PACE go from here? We have done everything that was asked of us to generate continued funding. As a director of a program I am perplexed by the system of seed money.

If project PACE is not refunded many seniors will not receive needed mental health counseling. We will not be able to provide training to senior volunteers wishing to become counselors The strides made in getting seniors to understand mental health counseling will be lost

It is very difficult to run a program when you are constantly wondering about your next nickel. It is even harder to realize that many seniors suffering from a loss of spouse, a disabling illness, or a myriad of other age-related problems will not be able to receive counseling assistance.

I invite the reader to call or write and discuss these issues. Project PACE needs the public to recognize the critical nature of the funding dilemma.

CHRISTOPHER HAYES.