Counseling Programs for Older Persons: Status, Shortcomings, and Potentialities

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Article:

Introduction

The intent of this article is to examine programs and services designed to meet the psychological and psychosocial needs of older people. Knowledge of existing programs is important to planning purposefully and to advancing the development of our field. Therefore, following a historical overview that will provide a perspective for examining mental health services, a variety of settings and programs that provide counseling for older people will be described. These include traditional care settings and programs, emerging settings and programs, and some alternative programs to help meet specific areas of need. This article concludes with a discussion of the gaps and potentialities of the existing delivery system for more adequately addressing the mental health needs of older people.

An Historical Perspective

The stigma of mental illness has, in many ways, affected all age groups equally; lack of understanding has led society to fear and reject mentally impaired persons throughout recorded history. Traditional approaches to care for mental illness have been largely custodial and have been provided primarily in facilities such as asylums, hospitals, rest homes, and others far removed from the mainstream of life. It has been only within the last 100 years that we have begun to achieve some understanding of the phenomenon of mental illness, and thus have less systematically and routinely isolated ill individuals from the mainstream of society and have begun to provide more therapeutic treatment.

While in the past, severe problems frequently led to some form of institutional care, today community care alternatives are increasingly common. A major impetus for this change was "the assumption that natural support systems could more effectively take over many of the life- support activities of the large state mental hospitals and provide a better mental health milieu for the patient" (Litwak, 1979, p. 34). The national scope of the deinstitutionalization movement reflects a stance that family and friends form an important component of the network of supports needed to help mentally ill persons live more independently in community settings. Other natural caregivers may include persons such as ministers and physicians, who interact with older individuals and provide help in times of crisis. These informal supports often supplement or supplant the role of formal organizations, including outpatient community mental health centers. This is due, in part, to the fact that these natural caregivers always have been there, while more formal organizational supports have been more tenuous, with service priorities, eligibility determination, and treatment modalities in fairly constant states of flux.

Additionally, even when formal supports for mental health care have been available to the general populace, older persons have not received their proportionate share of services. Cohen (1977) describes six major causes for the lack of accessibility between mental health caregivers and the elderly. First are negative attitudes prompted by the therapists' own fears about aging, unresolved conflicts with parents, feelings that older persons cannot change or be helped, beliefs that skills will be wasted because older people will die anyway, fears that older persons may die while in treatment and thus negate the therapists' omnipotence or sense of importance, and concern about negative feedback from peers for being morbidly concerned with death; second, therapists' myths and ageist beliefs about older people may result in failure to recognize problems that do in fact exist and are treatable; third, economic concerns have precluded treatment of the aged; fourth, therapists may fear

becoming overwhelmed by the multiple problems of older persons; fifth, the older person may have limited mobility and hence difficulty getting to the therapist's office; and sixth, society has been slow to respond to the needs of older persons due to rampant ageism.

As mentioned earlier, much of the traditional response in terms of programs of mental health services for older persons has come from the public sector. This has included public clinics, general hospitals, and state mental hospitals. The failure of public clinics and hospitals in the community to provide adequate care often resulted (and results) in commitment to state mental hospitals where, again, therapeutic services are limited. The private sector has provided only limited response to older persons for reasons noted earlier, as well as because mechanisms for payment for services have been limited. If more Medicaid and Medicare dollars for private psychiatric and psychological services become available, we might expect increasing shifts of emphasis in this area.

Another area of the private sector which currently has the potential for a major impact on the mental health of older persons is the nursing home industry; however, positive impact may not be felt without significant public sector input. Two facts emphasize this point. First, the 4-5% figure for older persons residing in institutional settings is representative of large numbers of older persons, over 1,000,000 of them. Second, this figure is misleading, since it represents the number institutionalized only at a given point in time. The number of older persons who will be institutionalized at some point in their life is much larger than the 4-5% that are institutionalized at any one time. This explains the fact that over 30% of older persons die in these settings. (Levy, Derogatis, Gallagher & Gatz, 1980).

Obviously, the potential for mental health care in both public and private settings exists and needs to be tapped. In the past, public mental health care has stemmed primarily from the federal government and went directly to CMHCs, bypassing the state governments. Other, although substantially less, monies came from state, local tax dollars and fees.

Under the new block grant system, federal mental health funds go directly to the states, each of which determines its own priorities for funding throughout the state. Further, block grant monies to the states were cut by 25% from the previous year of federal funding. While it is too early to determine and comment on patterns and levels of mental health funding, one can nevertheless project with a fair degree of certainty that highly variable funding patterns will emerge among states; and reflecting the decrease of federal funds, it is likely that funds to clinics, including the geriatric programs, also will decrease. Whether and how much of these funds are allocated to mental health programs for older people will depend in large part on the advocacy efforts of mental health professionals and concerned others in each state.

Private mental health care is supported primarily from nongovernmental sources (patient fees, United Way, private donations, etc.). Many programs receive both public and private support. Although a number of privately financed programs exist throughout the country, the major programmatic impact seems to have come from the federal level. With the major changes now underway, emerging patterns may be quite different.

Numbers of model programs for research and demonstration nationwide are, or have been funded by the U.S. Administration on Aging (AoA) and the National Institute of Mental Health (NIMH). Other funding sources include private trusts and foundations, churches, and other private organizations. Space does not permit an in-depth discussion of programs provided by each of these sources. What follows are descriptions of a cross-section of service programs, with notations of funding sources provided where appropriate. These can serve both as models and to provide an indication of the kinds of services available in various locales. The reader must keep in mind that the programs discussed in this article are seldom static. Many may have expanded, some may have been discontinued, and others may have changed in other significant ways by the time this article is published. Unfortunately, counseling programs for older people often have been created and discontinued all within a brief period. Lack of well institutionalized funding adversely affects the continuity of services. Services often have more the nature of a project than a program.

Settings and Programs

In this section we will describe a variety of service programs which provide counseling and other mental health services to older persons. The focus is on community-based programs, since these are the emerging settings for the delivery of mental health care. The descriptions include programs characterized primarily by types of settings and/or programs characterized by function (i.e., special focus or purpose). The list and description of programs is not meant to be inclusive of all possibilities. Rather, it is intended to give the reader a working knowledge of the types of programs available, where they are located, and the sources through which they are funded.

Community Mental Health Centers (CMHCs)

CMHCs, though always operating with a mandate to serve persons of all age groups, have devoted little attention to servicing older persons. The situation has been so extreme as to provoke passage of P. L. 94-63, the Community Mental Health Centers amendments of 1975, requiring that federally assisted centers provide care for older people equal to that for persons of other ages (Patterson, 1979). In addition, the law required CMHCs to provide specialized services for older people, including a full range of diagnostic, treatment, liaison, and follow-up services.

Had the Mental Health Systems Act of 1980 been funded, it would have mandated more and quite specific services for older persons. Under today's block grant system, however, although the elderly are designated as a priority group to receive outpatient services, the law includes no specificity with regard to types of outreach services, other services, the extent of services, or funding levels.

Over the years, many services, including the consultation and education roles, apparently have been largely neglected in relation to all persons served by CMHCs. That is to say, the centers have tended to have "individual focused programs instead of population or public health focused programs" (Patterson, 1979, p. 256). With some exceptions, this holds true for geriatric mental health programs as well. Where such programs actually do exist, it seems plausible that center staff, experiencing bias or ageism with respect to individual older persons, have not developed comprehensive programs nor actively advocated for aging concerns within the community. Because of recent changes in mental health legislation, professionals in geriatric mental health are dubious about the development and even maintenance of mental health programs for outpatients. Without strong advocacy efforts, particularly at the state level by mental health and other concerned professionals and citizen groups, improvement in geriatric mental health programs throughout the nation is precarious.

In order to update the "state of the art" with respect to provision of services to older persons through CMHCs, one of the authors sent a letter to the state mental health offices requesting information. In total, 56 letters were sent in the Spring of 1980, including six to the American territories. Twenty-five responses were received to the request for information. Interestingly, irrespective of the federal legislative intent, at that time several states reported that they had no special provisions for services to older people and, further, that they were under no legislative mandate to do so. In one instance, we were referred to the state aging program office to learn about mental health services specifically for older people, because the state mental health offices had none. These state programs were, fortunately, among the minority of those that responded. Other states, Indiana, Iowa, and Washington, among others, seemed to have strong working relationships between the state mental health and aging offices. In view of the response rate of 48%, the question of whether or not other states are providing services to older people remains an interesting but not fully answered question (see Myers, 1982).

Those states which reported providing mental health services to older persons indicated substantial variation in delivery systems. Several states gave an overview of their total mental health system and indicated that, in general, older persons were served in that system. Some stated that older persons were served according to the extent of their need in all state mental health programs. A common response was that few persons seen in community clinics were elderly and that most programs for older persons involved inpatient care. The availability of special funding from NIMH was often the key element in the establishment of special programs

to serve older people, though this was not always the case. The following program descriptions are intended to provide examples of some of the more diverse and innovative CMHC delivery systems.

The state of Maryland has a statewide system known as the Geriatric Evaluation Service (GES). Each county has its own local service which is mandated by law to screen and make recommendations on all geriatric patients being referred to state mental hospitals for psychiatric treatment. The GES also serves as a consulting agency in all cases of geriatric problems and recommends disposition to the appropriate state support service (Krajewski, Note 1).

The Counseling Services for Older Adults (CSOA) program in Lincoln, Nebraska, is an example of the strength of a CMHC-administered program for older people. Its purpose is to provide accessible, appropriate, and useful mental health services to older persons and their families. The focus is on preventive mental health care and on enhancing coping skills of elders. The multiple-funding sources for CSOA include federal sources (31 %), fees and third-party payments (15%), and state and county monies (54%) (Counseling Services for Older Adults, 1981). The program includes a strong outreach component and works closely with the local area agency on aging and its service programs, including Lincoln Information and Referral for the Elderly (LIFE), discussed below.

Since 1978 the Spokane CMHC has been committed to serving the older adult population of Spokane, both those residing in their own homes and those in long-term care facilities. A special concern has been devoted to the "frail" or "vulnerable" elderly who are moderately to severely dysfunctional. The Spokane CMHCs Elderly Services consists of two highly integrated component programs: (1) Telephone Information and Referral (T&R), and Multidisciplinary, Holistic In-Home Case Management. The T&R component operates on a county-wide basis and provides telephone information and referral services targeted at higher functioning older persons. The two full-time telephone screeners who staff the T&R component also provide referrals for the in-home case management team and provide telephone coverage for the Postal Alert Program, a program developed in cooperation with the United States Postal Service as part of a "gatekeeper" assistance to locating at-risk elderly. The In-Home Case Management component has written 13 coordination and referral agreements with other community agencies in an attempt to identify at-risk older persons in need of assistance. Once identified, these at-risk elderly are visited by members of the in-home case management team. One of the unique features of this program has been its ability to tap a wide range of funding sources. About 70% of the funding for the two components described above has come from the Eastern Washington Area Agency on Aging with the remainder of the funding coming from the National Institute of Mental Health, Washington State Mental Health Grant in Aid, and National Institute on Drug Abuse (Raschko, Note 2).

In summary, CMHCs provide a variable rate and range of services to older people. Regardless of legislative mandate coupled with steady progress in positive directions, we have a long way to go. The CMHCs described above represent exceptions. Not many CMHCs are allocating a fair share of mental health services to meet the needs of older persons. The goal of maintaining people in the community is a viable one, however, and the remaining programs to be described in this article exemplify other means for facilitating community living of mentally impaired and/or frail older persons.

Transitional Residential Care, Day Treatment, and Adult Day Care Programs

In addition to the day treatment programs mentioned below which are provided directly through CMHCs, many more programs exist which provide varying degrees of intensive outpatient community care. These programs are designed basically as alternatives to, or to prevent the need for, institutionalization as part of an attempt to maintain older people in the community. This section includes descriptions of transitional residential care or half-way settings and focuses primarily on day care centers. This is because the latter more fully represent what is meant by emerging settings. Additionally, the trend is toward multiservice agencies, where residential care is one component of a comprehensive mental health service delivery system.

Transitional residential care and day treatment programs. As is indicated by the title, programs in this category lie in the middle of a continuum that includes independent community living at one end and institutional care at the other extreme. They function to provide the respite and rehabilitative services needed to maintain community dwelling persons in their own homes as long as possible. An example of a comprehensive residential care and day treatment program is provided by the Southeast/Mission Geriatric Services Agency in San Francisco. The goals of this program are "to maintain the elderly in their own homes for as long as possible through early identification of problems, to prevent hospitalization through referrals to treatment before the condition becomes severe or, if required, to locate the most appropriate type of care for people needing 24-hour support services" (Ruffin & Urquhart, 1980, p. 102). To achieve these goals, this agency operates a transitional residential care facilty, a day activity program, in-home care, including initial evaluations by a therapeutic team, home visitations and follow-up, and referral for geriatric hospitalization or other needed services. Family and group therapy are provided, either in the home or office, and help assure that services are provided to persons needing them even if they cannot or will not visit the agency offices. Services provided by Sotheast/Mission Geriatric Services include preventive, therapeutic, supportive and rehabilitative programs. Its sources of funding are many, including California mental health funds, channeled through the Department of Public Health's Community Mental Health Service, Medicaid and Medi-Cal (as Medicaid is called in California), private fees and insurance payments, and a grant from the National Institute of Mental Health (NIMH). The offices are staffed by a large interdisciplinary team, led by a psychiatric social worker (Ruffm & Urquhart, 1980).

Another day treatment program which is funded and administered through a CHMC is the Esperanza Day Treatment Center for the Elderly in Casa Grande, Arizona. It is coordinated by a registered nurse who is assisted by a geriatric counselor. Services are provided in the home or at the outpatient clinic and include assessment, individual and group counseling, psychiatric and psychological evaluations and treatment, crisis intervention, community consultation and education, residential treatment and adult day care. The day care program operates six hours, four days per week and provides therapeutic, health and social services for older people having functional or psychological disabilities. Participants are required to attend at least two days per week and may receive a variety of services, including nursing, nutrition, counseling, therapy, casework, transportational and social, education, and recreational activities and advocacy (Bertrand, Note 3).

The Mental Health/Mental Retardation Center of Southeast Texas is another example of a comprehensive outpatient service agency operating at a CMHC. Along with a diverse array of social and therapeutic services, this program includes an intense day treatment therapy program four hours per day four days per week {Roe, Note 4}. Additional examples of programs similar in scope and content to those described above, yet each having unique features, are abundant {e.g., Browne, 1976; Goldstein & Carlson, 1976; Kostick, 1972; Lutrie, Kalish, Wexler, & Amsak, 1977; McDonald, Nuelander, Holrod, & Holcomb, 1971}. What most of these programs offer is comprehensive social services in an outpatient community care setting. It is important to distinguish these programs from adult day care, which is described below. The latter service lies somewhere between transitional residential care and day treatment in its scope of services, goals, and client/patient composition.

Adult day care. Adult day care is a relatively new service for frail elderly which serves four functions: prevention, attention, self-sufficiency, and extended family stability (Leonard, 1980; *News* & Views, 1981). It is a service which provides respite care for older persons in a center, as an alternative to nursing home placement. Use of adult day care centers enables families to maintain frail elderly members in the home while being free to carry on their own normal job and living tasks. Centers optimally operate eight to nine hours per day, five days per week and provide both emotional support and recreational activities for older persons. Others may operate a few days per week. A day center can have an important positive effect on the mental health of all family members by relieving them of some of the large amounts of time and effort that otherwise may need to be devoted to proper care (Group for the Advancement of Psychiatry, 1971).

Weiler (1978) discusses planning, services, and administration of day care operations for adults and provides examples of services and programs in the United States and Europe. Day care is essentially a long-term

arrangement, helping to prevent or postpone nursing home placement for significant periods of time which average 15 months (Leonard, 1980). Therapeutic intervention in centers is facilitated by many factors, including the trust which can develop between center staff and older persons and their families, as well as the fact that the older clients are at the centers for extended periods of time. A variety of health and social services may be provided in these settings, including nursing care, physical, speech and occupational therapy, nutrition, recreation, socialization, and others (Leonard, 1980; Weiler, 1978). Obviously, an interdisciplinary team is needed to provide effectively the gamut of services needed by severely impaired older individuals.

The provision of counseling or therapeutic services in adult day care settings is enhanced by the frequency of staff contact with the clientele and hence a greater potential for establishing rapport. However, it is important to note that many of the barriers to mental health care which were discussed earlier continue to exist, particularly the stigma attached to receiving such care. Often this can be overcome in day care settings by making counseling an "integral and incidental part of the program" (Leonard, 1980). This is accomplished in many centers, including the Daily Living Center in Oklahoma City, with counseling services provided by Project S.E.N.I.O.R. (Cook, Note 5) and the several adult day care programs sponsored by the Foundation for Senior Adult Living, Inc. (FSAL) in Phoenix, Arizona (Leonard, 1980).

Although adult day care programs remain scarce nationwide, there has been a remarkable growth in the number of such programs over the past decade. Ten years ago the federal government supported only four experimental day care programs. In 1974 fewer than 15 programs could be identified. But in 1977, the *Adult Day Care Directory* (1980) listed over 200 programs (Robins, 1981).

Long-Term Care Facilities

Institutional care, or placement in long-term care facilities (LTC), or nursing homes, is sometimes unavoidable and appropriate. These facilities, though often frowned upon and feared, serve useful purposes in providing 24-hour-a-day care for those older persons having health care needs which exceed the abilities of the family and community support systems to provide for them. They need not be halfway houses that lie somewhere between society and the cemetery (Buder, 1975); in fact, it is increasingly being recognized that death is not the "only way out" of an LTC facility, and that a return to community living is possible. Whether or not an LTC facility is permanent or temporary placement, counseling services have an important role to play. Counseling has potential contributions whether a resident is concerned about imminent death, dependency, or successful coping behaviors in the community. It is helpful if counselors' work goes beyond individual residents to working with their families as well. Although it is important to recognize that supportive mental health services in the community lead to lowered rates of institutional care (Wolf, 1976), it is equally as important to recognize that the provision of mental health care in an institutional setting can raise the rate of return to community living.

Much of the literature describing mental health services in institutional settings is comprised of research reports showing the efficacy of various therapeutic modalities with an institutionalized population. These include research on intervention strategies such as structured group interaction (Lago & Hoffman, 1978), social interaction (Blackman, Howe & Pinkston, 1976), social skills acquisition (Lopez, 1980), companionship therapy (Arthur, Donnan & Lair, 1973), and increased physical activity (Clark, Wade, Massey, & Van Dyke, 1975), to name a few. Of course, many of the residents of LTC facilities who participated in these studies derived some benefit from the care they received. The point to be made is that we do not have extensive knowledge of the kinds of treatments that work with the very frail elderly. In addition to the many studies implemented to fill this gap in our knowledge base, a variety of mental health service programs have been implemented on an ongoing basis in LTC settings.

Reality Orientation Therapy (R.O.), designed to help reorient confused geriatric patients, reduce memory loss, and increase awareness, has been used with reported success in many facilities. One example is the Pine Knolls Nursing Home in Carrollton, Georgia, where a 24-hour R.O. program was instituted. All staff on all shifts implemented R.O. principles in their contact with participants. The program also included R.O. classes for 30 minutes of each day for groups of three to four patients. Reality Orientation boards were used which contained

basic information such as the name and location of the facility, the date, days of the week and so on (Barnes, 1974). The Veterans Administration Hospital in Tuscaloosa, Alabama, has also developed this technique and has been a pioneer in the field (Barnes, Sack, & Shore, 1979; V. A. Hospital, Tuscaloosa, 1970).

Another concept requiring total staff involvement is that of creating a therapeutic community. In general, this refers to a setting wherein the totality of care provided maintains a therapeutic focus. All staff are trained to help meet patient goals, and all, including aides and volunteers, function as members of the therapy team on a 24-hour basis. In addition to the general staff orientation, individual treatment plans are implemented for individual elderly persons with maximum staff and family involvement in each treatment plan. Social and environmental dimensions of care are viewed as critical components of mental health services, in addition to traditional psychiatric services Oones, 1968). This approach was used at the St. John's Home for the Aging in Rochester, New York, and was housed in the establishment of a mental health unit within the skilled nursing facility (Colthart, 1974). The objective of helping mentally impaired older persons to regain maximal functioning was met most often when therapy programs were tailored to the needs of the individual and included, a variety of treatment approaches, including R.O., remotivation therapy and social get-togethers.

Milieu therapy is a form of the therapeutic community which also has been reported successful with a variety of inpatient populations (Berkman, 1977). As the name implies, milieu therapy is a technique for modifying the environment to provide facilitative conditions for treatment. It includes the total staff involvement and 24-hour care which are characteristic of the therapeutic community concept. Beyond this, milieu therapy seeks to involve the patient as a member of the treatment team, and incorporates a focus on independent living, making the treatment milieu resemble a normalized environment to the extent possible. The underlying assumption is that the total environment is itself a form of treatment (Lawrence, 1981).

The Geri-Center at Duke University Hospital, funded by grants from the North Carolina Department of Mental Health and other sources, established a milieu therapy ward to facilitate resocialization of geriatric patients in preparation for a return to the community. Although not totally successful in achieving its goals, this program's attempts served to point out the importance of staff training for an effective therapeutic environment (Smyer, Siegler, & Gatz, 1976). Greater success with milieu therapy was achieved at the VA Hospital in Coatesville, Pennsylvania, in a cooperative endeavor with the West Philadelphia Community Mental Health Center Consortium (Steer & Boger, 1975).

Donohue, Gottesman, and Coons (1981) implemented an NIMH-sponsored study from 1961 to 1970 that helped establish milieu treatment as a means for improving the lives of geriatric patients in state mental hospitals. Emphasis in this research demonstration study was placed on wellness as opposed to sickness, independent living with some nursing care, and ultimately, where possible, placement within carefully selected community settings. This project laid the groundwork for rehabilitating older persons to resume useful, meaningful, and productive lives. Results of the study have caused nursing homes, other long-term care facilities, and Hospital Improvement Programs (HIP) to be more conscious of the mental health needs of older patients.

The programs associated with LTC facilities that have been discussed above provide evidence that there are some LTC institutions that are attempting to meet the mental health needs of older persons.

Housing Settings

For some older persons, living in a congregate or public housing setting, with ready access to social services, may be the key to residing independently in the community rather than entering a nursing home. Some programs in these environments (with mental health services) are described below.

At the University of Wyoming, graduate students in counseling together with a counselor educator developed a program to provide group counseling to elderly women residing in a residential home near the university. The home housed 25 women, aged 65 to 96. Nine counseling sessions covering the following topics were provided: (1) giving and receiving positive strokes, (2) personal treasures and friendship, (3) counseling and assertiveness,

(4) values clarification, (5) independence versus dependence, (6) decision making, (7) sculpturing, (8) loss and loneliness, and (9) strength bombardment. As a result of this program, which operated without outside funding, guidelines have been developed for facilitating groups for aged women (Capuzzi, Gossman, Whiston, & Surdam, 1979). Careful documentation has been provided regarding the specific content of each counseling session, and counselor observations have been reported on the outcomes of the experience.

An example of a program in a congregate housing setting is that operated by the Ebenezer Society, which oversees six residential facilities housing 800 older persons in urban Minneapolis. These accommodations include 248 skilled nursing beds, 130 intermediate care beds, 17 board-and-care beds, and 200 apartments. The Ebenezer Society began in the early 1900s when a group of Lutheran congregations in the Minneapolis-St. Paul area joined together to provide services for needy older persons. A program has emerged that includes extensive housing, medical, social, and psychological services. The Human Development Project has spearheaded the mental health services component of the Ebenezer Society. In 1967 Rev. A. J. Blake began a program called "Maintaining the Growing Edge" which eventually received funding from The Lutheran Brotherhood. This program became more formalized into the Human Development Project in 1974 when NIMH funding was received for research, program development, and evaluation. Originally, the program focused on enhancing the self-esteem of some of the more severely impaired older persons by rehabilitating their independent living skills and increasing their ability to participate in social activities. The program has emerged into a highly comprehensive one that conducts numerous personal growth and discussion groups. Very clearly defined mental health goals and objectives have been established for the program. Staff have reported that the most common psychosocial need of the residents is that of general life enrichment and that at least 60% of the residents have that need (Glasscote, Gudeman, & Miles, 1977).

Cathedral Square Towers, an apartment complex for older persons (62 years of age or older) and handicapped persons offers counseling services for its residents. Located in downtown Kansas City and operated by the Catholic Diocese of Kansas City-St. Joseph, this 156-unit congregate housing complex has developed a health maintenance/activity program that has been evaluated as helpful and essential in enabling many of the residents to continue independent living. Individual and group counseling is an integral part of this program. Approximately 30 hours of counseling are provided each week by a professional counselor who is also a registered nurse. The main goals of the counseling program, which is partially funded by Tide XX (Social Security Act), are to assist the residents in achieving and maintaining self-sufficiency and preventing dependency and inappropriate institutional care. Since the program started approximately three years ago, some 60 residents have been involved in group counseling and 50 in individual counseling. The age range of participants is 74 to 94 years (Thibodeaux, 1981, Note 6).

Community Social Service Agencies

Within the community, numerous agencies exist to provide social services to older persons. Some of these include a counseling component. Services may be provided in either the agency offices or the older person's home.

An example of the former is the Freda Mohr Center of Jewish Family Services in Los Angeles. The Center is a storefront, walk-in counseling service for older persons located in the predominantly Jewish area of Beverly-Fairfax. This location was purposely chosen because it is highly accessible in the shopping area of the targeted group of older Jewish persons. Originally, the purpose of this Center was to help older persons to deal with the problems of aging as normal and natural concerns of living and to develop positive feelings about the aging process. Currently, this Center prides itself on having a program which is highly responsive to a wide variety of needs of older persons. Three types of groups are frequently implemented: (1) life development groups, which have a preventive focus and help older persons to deal with common stresses experienced in later life; (2) coping groups, which emphasize support and socialization; and (3) insight-oriented therapy groups, which tend to be long-term and open-ended, analytically based, and risk-taking (King, 1977).

The Mount Sinai Medical Center, located close to the inner city of Milwaukee near many minority and economically impoverished older persons, is an example of a program which provides in-home services. In 1976, when a few staff persons began to investigate the possibility of offering outpatient services for older people at the psychiatry clinic of the Center, neither professionals nor potential service recipients were enthusiastic about the idea. Nonetheless, a proposal was developed and funding totaling $25,000 was received from the Milwaukee County Commission on Aging. This program has developed many features that help to make it effective with older persons. These features include: (1) a volunteer board of advisors whose members are at least 60 years old; (2) an emphasis upon outreach that generally results in initial contacts being made m the homes of potential clients; (3) encouragement of family counseling to ease both intergenerational stresses and those between spouses; and (4) a strong advocacy program that actively pursues eliminating ageist stereotypes and behaviors in the community (Selan & Gold, 1980).

Senior Centers

Senior centers and nutrition programs, many of which are funded through the Older American Act, sometimes include a counseling component. Two such programs are described below.

The Northside Neighborhood Family Services, Inc., in Miami oversees a highly atypical senior center. The Neighborhood Family was launched in 1974 by the head of the gerontology unit of the Jackson Memorial Hospital Community Mental Health Services. The latter is a mental health center which serves a catchment area in Miami that is characterized by high crime, high drug related accidental deaths and high suicide rate, and numerous social and economic problems contributing to these conditions. Neighborhood Family was created as a satellite site of this mental health center to help prevent emotional dysfunction among older persons. Neighborhood Family serves an area several blocks square within the problem-ridden catchment area of the center. Over half of the approximately 1,100 housing units targeted by Neighborhood Family are mobile homes. Approximately 300 persons 60 or more years old live within this geographical area. The facility of the Neighborhood Family is a converted warehouse within the Northside Shopping Center. Most of the activities of typical senior centers are offered at the site, but there is far more emphasis upon medical and psychological assessment and the provisions of psychological services than is generally true of such centers (Glasscote,Gudeman, & Miles, 1977).

Holiday Park Senior Center in Wheaton, Maryland, typifies a different and unique approach to mental health care in a senior center setting. A private nonprofit community psychiatric clinic in Wheaton contracts with the local health department to provide needed mental health services. Surplus funding from the contract is used to support counseling services at Holiday Park two hours on two weekdays. This is a walk-in service advertised as "counseling," not psychological services. Staff within the senior center assist in referring older persons to the service. The basic idea is for people with problems to have ready access to a psychiatric social worker for one or two visits without charge. Further services are provided on a fee basis, under the supervision of a psychiatrist. This appears to be a successful and ongoing project (Wasserman, Note 7).

Religious Organizations

Religious organizations can be an important source of counseling assistance for older persons. An example of an innovative approach in the delivery of services through organized church groups is Project CHOICE (Atkins, Note 8). A consortium of different denominations in the St. Louis metropolitan area supports this project aimed at improving ministry to older persons through the church. A minister who also has counseling skills has been hired to work with other pastors and with members of congregations in developing counseling and related programs for older persons. Project CHOICE has a continuing education component for the clergy that includes sessions in which pastors share conversations that they recently had with older persons, sermons that they have presented on the topic of aging, and discussions with members of families concerned about older members. Ministers also receive instruction on the aging process and other basic gerontological information. In addition to its program for the clergy, Project CHOICE conducts conferences aimed at helping laity to care better for older members of their respective congregations, and provides various life enrichment and preretirement programs for

older people themselves. A feature of this program worth noting is its interdenominational support (Atkins, Note 8).

The Shepherd Center, located in Kansas City, Missouri represents a more widely publicized example of how church leaders can spearhead the provisions of a wide range of services for older people. In 1972 eight church leaders from five different congregations started the Shepherd Center primarily for the purpose of helping older persons remain in their homes. Originally the target area included 53,000 people 11,603 over the age of 65. The first goal was to provide services needed for survival (meals, transportation to medical facilities, etc.), but educational and other life enrichment services soon followed. These latter services include Adventures in Learning, a program that includes a wide assortment of classes ranging from money matter courses to yoga, and a Life Enrichment Center, a program which provides professional leadership and peer support to assist older persons to experience love and understanding at times when their physical, emotional, and spiritual resources have been severely reduced. Several of the programs discussed in other sections of this article are also church-sponsored or -affiliated.

Alternative Types of Programs

In this section we will review a variety of alternative types of programs developed to provide the kind of support referenced above. The program descriptions are divided into those which are more generic and address themselves to helping older persons meet their needs in many areas, those which focus on more specific areas of need, those which serve specific populations, and those which use specific helping approaches.

Generic Programs

Generic types of programs, or those which attempt to provide comprehensive care to meet the needs of older persons, are faced with a difficult task. One such program, forced to substantially reduce its services when federal funding terminated, is the Turner Geriatric Clinic in Michigan. In addition to outpatient medical services, an AoA grant between 1978 and 1980 was used to expand the range of services to include peer support and a general learning program for older people. Small and large group sessions were used to help older individuals cope with chronic and emergency situations and develop preventive coping skills. The group sessions focused on diverse topics such as loss of vision, widowhood, stress, human sexuality, and conversational French, to name a few (Campbell, Note 9).

In Chicago, the Council of Jewish Elderly sponsors another program to maintain older persons in the community. Area service centers are used to provide needed preventive mental health care to older persons in several small geographic portions of the city (Weinberg, 1979). Each service center covers a catchment area of a few square blocks and provides an extensive and intensive array of services to residents within that area. A great deal of emphasis is placed on outreach, case finding, and referral. Psychiatric consultation is an integral aspect of this program (Finkel, 1980). Health and social services, including counseling, are provided both in the center and through a program of in-home services. A group-living residence, several apartment buildings, a day care program, and several nutrition sites operated by the Council are all major components of the service delivery system (Glasscote, Gudeman, & Miles, 1977).

Another example of a comprehensive service program is Douglas Gardens, in Miami, which includes comprehensive service programs in both the main facilities of the Miami Jewish Home and Hospital for the Aged and other activities of an extensive program which includes a day care center and a satellite outpatient center some miles away. The eleven-acre tract of the main facilities is intended to be a beautiful and therapeutic setting for residents. The gerontological mental health center component of the Douglas Gardens complex was established in 1974 and has been described as the first organization of its kind. This center was created in part because of the recognition of the staff that there was an exceptionally long waiting list for residential care and that many persons died while awaiting admission. Currently, a comprehensive mental health program is offered to persons 50 and over who are living in the community and can benefit from specialized counseling services related to the problems of old age. These services include psychiatric testing and evaluation, psychological testing, individual, marital, family, and group therapy, medication review, and occupational therapy. In addition

to services offered during regular working hours, there is an after-hours emergency answering service. Staffing at the center includes three psychiatrists, two psychologists, 12 psychiatric case workers, two intake workers, and the staff of the occupational therapy department. Older persons who receive these services pay on a sliding scale, up to $25 per visit. The average payment is $2 (Glasscote, Gudeman, & Miles, 1977; Ronch & Solomon, 1978).

Programs that Focus on Specific Needs

In contrast to those programs having a generic approach to counseling for older persons, many exist which provide services that focus on a particular goal, problem, or aspect of older people's lives. Again, the descriptions which follow are not inclusive of all such programs. They include descriptions of counseling services programs which attempt to meet the needs of older individuals in the areas of personal growth, dying and survivorship, employment, and education.

Personal growth. The program of the Continuum Center of Oakland University, described later in this article under Paraprofessional and Peer Counseling Programs, includes a self-exploration set of activities which aims at personal growth. This is an important component of the overall program, which is offered in a variety of community centers in the Detroit metropolitan area (Waters, Reiter, & White, 1976). An outgrowth of the personal growth and relationship skill-building aspect of this program is a manual that assists others to replicate activities that have been considered successful (Reiter, Waters, Weaver, & White, 1979). This program is also mentioned under the peer counseling section.

Another program which is oriented towards personal growth is the Family Life Center of the Greater Dubois Area, a division of Tressler Lutheran Service Associates, which conducts the Counseling for the Elderly Program in Clearfield County, Pennsylvania. This service is provided through a subcontract to the Clearfield County Office of Aging through Tide XX (Social Security Act) resources. Free counseling services are offered to anyone 60 years of age or older. The primary emphasis of the program is on personal-social counseling, with a secondary emphasis on informational guidance. Both individual and group counseling are provided in the program which is offered throughout the county's six outreach centers. The counselor who provides the services devotes three hours per week to each of six county outreach centers and is also available for in-home appointments (Shearer, Note 10).

Dying and survivorship. In Richmond, Virginia, a widowhood peer counseling project was developed to assist widows who did not have either family or friends to assist them in their adjustment to widowhood or had insufficient help from these sources. This project was funded by a grant from the Virginia State Agency on Aging and the Gerontology Department of Virginia Commonwealth University. The project assists widowed persons 55 years old and over who experience difficulty in emotional, psychological, or social aspects of widowhood to receive understanding, support, and other help that may be needed. Initially, 15 widows were selected to enter training. The training consisted of 12 weekly two-hour sessions which focused on three areas: (1) the development of a working relationship and sense of cohesiveness among the participants, (2) the development of sensitivity toward and understanding of bereavement, and (3) experiential learning techniques including roleplaying and various forms of simulated counseling experiences. Once trained, the peer counselors work closely with staff and graduate students of Virginia Commonwealth University in implementing the counseling program (Romaniuk & Priddy, 1980).

Another program that assists widows and widowers to cope with their altered circumstances is the Widowed Persons Service (1981) sponsored by the National Retired Teachers Association-American Association of Retired Persons-Action for Independent Maturity (NR T AAARP-AIM). This national association has prepared organizational and training manuals which describe services for widowed persons including outreach, telephone reassurance, group discussion sessions, public education, and referral services. These resource manuals are available to AARP chapters in the local communities across the country. NRTA-AARP-AIM publishes a guide to widowed persons entitled "On Being Alone." This brochure discusses bereavement, family adjustment,

employment and careers, financial and legal affairs, and other matters of likely interest to widows and widowers. Single copies are available at no cost (NRTA-AARP-AIM, 1981).

Employment. A variety of nonprofit and public programs exist to help meet the employment needs of older people (Benight, 1981). The Older Worker Employment Program, operated by the Mayor's Office of Manpower Resources in Baltimore, Maryland, is operated through a large, centrally-located senior center, and includes counseling and referral to subsidized jobs funded by CET A. Clerical and home health aide training are conducted for interested persons who lack such skills. In addition, older persons having marketable skills but difficulty finding jobs can receive counseling and referral assistance Gohnson, 1980).

In 1971 Yale University's Office of Volunteer Services helped establish a program titled WHEEE, for We Help Elders Establish Employment. VISTA workers were used to begin the employment service; and federal funds, received in 1978, and additional funding received from the National Council of Senior Citizens has enabled the service to continue. All applicants are interviewed, counseled, and referred for placement. They also are contacted following employment to determine job-related concerns (Radding, 1980).

The Challenges of Maturity Program, funded by the Arizona Department of Education, provides outreach vocational guidance services for older workers. Operating in Tucson, the program offers training workshops in the area of job seeking skills, counseling, and community activities (Stein, 1981).

A variety of special employment programs are funded through federal sources. Title V of the Older Americans Act, known as the Senior Community Service Employment Program, is administered by the American Association of Retired Persons, under the auspices of the Department of Labor. Funds support the hiring of older persons to work in community agencies, especially those delivering services to older people. Staff provide vocational counseling and referral and individual assistance with job seeking skills where needed. Part-time employment is typical and meets the physical and emotional capabilities and needs of many older individuals.

ACTION funds several well-known employment service programs for older persons, including the Retired Senior Volunteer Program (RSVP), Foster Grandparents (FGP), and the Senior Companions Program (SCP). Each of these programs provides minimal financial support, including travel funds, meals, medical screening, and minimum-wage level stipend, and the focus is on providing meaningful work activities that provide a service in the community. RSVP volunteers work in a variety of community agencies, performing a broad spectrum of activities from office work to horticulture and carpentry. Foster grandparents work with children, and handicapped children in particular. Many are placed in state institutions for retarded citizens, and others work in community schools for disabled children. Senior companions, as the name implies, serve as friendly visitors to handicapped or isolated elderly persons. Readers interested in learning more about these programs are encouraged to contact the Administration on Aging and the American Association of Retired Persons, both in Washington, D.C.

Education. Some of the employment programs discussed above offer educational services to prepare older individuals for specific kinds of work. In addition, programs designed to meet general educational needs of older people exist around the nation, and many of these are sponsored by two-year institutions. Counseling is an integral aspect of these programs, and tends to extend beyond counseling concerning coursework. Some examples of these programs follow.

Del Mar College in Corpus Christi, Texas, builds educational programs for older persons based upon their specific problems such as role loss, transportation, loss of friends, and death (Newman, 1980). This program was a direct outcome of a strong advocacy effort to increase educational opportunity for older persons, which resulted in an amendment to the Texas Education Code in February, 1975. This amendment permitted the governing board of a state-supported institution of higher education to allow persons 65 years of age or older to audit, if space is available, any course offered by that institution without the payment of a fee. Del Mar College then began offering this privilege to Corpus Christi residents aged 65 or older. The college also funded a

halftime position of Coordinator of the Del Mar College Senior Citizens Education Program. The program has developed into one that not only permits persons 65 years and older to audit classes tuition-free but also offers classes to persons aged 55 and older, taught by retired professionals on a volunteer basis. An Advisory Committee comprised of representatives from key agencies that serve older persons in the community has helped to make the program successful. Through this program older persons meet many diverse needs, including learning new hobbies and skills, obtaining knowledge and understanding in academic areas, exercising social skills, and increasing physical fitness (Newman, 1980).

The Academy for Education Development (AED, 1974) has reported numerous educational programs for older persons including those which have counseling components. These programs include:

Project GREATEST, an acronym for Giving Recreation, Education, and Assistance to Elderly Seniors Today, has been offered at Seminole Junior College, Sanford, Florida. It provides a counseling and information service that notifies older persons of ongoing activities in senior centers, instruction for recreation and leisure, and adult education classes. Another program, at the University of Wisconsin-Milwaukee, has enabled a psychologist and a counselor from the continuing education program to travel to neighborhood libraries on a prearranged schedule to counsel adults (many of whom are 50 and over) concerning educational opportunities, new career and volunteer possibilities, and high school or college level equivalency examinations. A third program is conducted at Catonsville Community College in Maryland. This has offered a Lunch Plus nutritional and social service program for persons 60 years and over. In addition to one hot meal a day, five days a week, a coordinated program of education, transportation, information, recreation, and counseling services has been provided (AED, 1974).

Programs That Assist Specific Populations

Three underserved populations in terms of mental health services are disabled older persons, older persons residing in rural areas, and minority older persons. Programs that are helping to meet the needs of these populations are discussed below.

Disabled elderly. A variety of rehabilitation settings exist to help mentally and/or physically frail elderly remain in or return to community living. Some of these involve outpatient care clinics attached to hospitals, and others include day hospital care (Group for the Advancement of Psychiatry, 1971). An example is the Senior Citizen's Health Center at St. Luke's Hospital in Denver which provides a variety of social services needed for crisis intervention and health maintenance (Caley, 1979).

Other programs are oriented to more specific problem situations, such as the Andrus Older Adult Center, affiliated with the University of Southern California, which conducts treatment and support groups for older persons having Alzheimer's disease and for their families. It is affiliated with the Alzheimer's Disease and Related Disorders Association which is oriented toward providing education, patient care, research, and advocacy (Getz, 1981). Another example of a program focusing on a specific problem is the New York League for the Hard of Hearing. This agency provides therapeutic counseling, under the supervision of a psychiatrist, for hearing impaired adults and elderly persons (Green, Note 11).

An additional program serving disabled elderly persons is a Project With Industry program in New York. Operated by the Academy for Gerontological Education and Development and funded by the National Institute for Handicapped Research, this project seeks to meet the counseling and job placement needs of older disabled persons (Housman, Note 12).

Rural delivery systems. The delivery of mental health services in rural areas has compounding problems. Although service needs may remain the same as for urban elderly, large distances limit access between care givers and older persons (Rural elderly need-and get help, 1978). In Arkansas, the access problem is partially resolved by housing the CMHC with the rural health clinic (Special Committee on Aging, 1980). Older persons seeking health care, a non-stigmatized service, may at the same time receive needed mental health services. The

North Arkansas Human Services System, Inc., operates as a private nonprofit corporation. Services available on a free or sliding fee basis include preventative and treatment aspects of mental health care for a 10-county area. A variety of media are employed to make the services more visible, and outreach workers regularly visit senior centers and other places where older people congregate to provide personal contact between the System and older persons needing mental health and other forms of care. A centralized, toll-free W A TS line provides information and referral and crisis intervention. Through integrating basic health and social service programs in a multicounty area in North Central Arkansas, this program has achieved much success in strengthening natural support systems and improving access to mental health care (Huddleston, Note 13).

Rosen and Rosen (Note 14) reported on an AoA-supported project that established geriatric counseling groups in 10 senior centers that served rural poverty level elderly near Athens, Georgia. The participants were considered high risk for potential development of mental health problems. The members of the geriatric counseling groups (N = 74) were matched with controls and followed at least one year. Preliminary findings indicated that the therapy group members, in contrast to their controls, were interested in being active and showed greater improvements in self-esteem and morale.

Relatively few programs and studies have been reported in regard to mental health services for older persons in rural settings. Although there is evidence of some successful programs such as those discussed above, mental health services for older persons in rural settings remains a relatively unexplored area.

Minorities. Butler (1975) discussed some of the multiple problems associated with being both a member of a minority group and old. Such persons tend to be poorer than the general population, have more health and nutritional problems, and less access to medical care and other needed services. They endure and often suffer from the cumulative effects of a lifetime of racism, compounded by the effects of ageism in their later decades of life. Vontress (1980) also enumerated some of the problems associated with counseling older minority persons. He stated that most of the problems of older minority persons center around their basic needs and that to be effective their counselor must become aware of the difficulties the older minority person faces in meeting these needs.

Although the literature provides much support for developing innovative programs tailored to the special needs of older minority persons, few such programs have been reported. In this area, program implementation appears somewhat removed from theory.

Programs That Use Specific Approaches

Two approaches related to providing counseling services to older persons that are currently being used extensively are paraprofessional and peer counseling, and information and referral services.

Paraprofessional and peer counseling. Many paraprofessional and peer counseling programs have emerged in recent years. A widely recognized program is that of the Continuum Center of Oakland University in Rochester, Michigan, which has operated since 1972. It has used a wide range of funding, including monies from the National Institute of Mental Health, the Administration of Aging, municipalities, and labor unions to offer counseling services to older persons in the metropolitan Detroit area. The focus of the Continuum Center Program is on group counseling, and much emphasis is placed upon the use of peer and paraprofessional counselors. Services are provided for older persons affiliated with community centers, residential settings, and various other sites where older persons regularly convene. The program has a developmental emphasis which is reflected in its title, Personal Growth for Older Adults. Human potential activities such as values clarification and strength acknowledgement are included in this program. Improving one's communication skills is also emphasized. This program has been reported widely in the literature (Bolton & Dignum-Scott, 1979; Waters, Fink, Goodman, & Parker, 1976; Waters, Reiter, White, & Dates, 1979; Waters, White, Dates, Reiter, & Weaver, 1979).

The Andrus Gerontology Center of the University of Southern California has developed a peer counseling program for the elderly as a component of the counseling service for older persons in the Los Angeles area. The peer counselors are selected from the pool of volunteers who help with one or more of various activities offered at the Center. The training is based upon the Carkhuff model and consists of 20 one and one-half hour sessions which are offered twice weekly. Following training, the peer counselors are incorporated into the counseling programs sponsored by the Andrus Center. Some peer counseling is done independently, but much is done in concert with professional staff counselors (Bolton & Dignum-Scott, 1979). Kerschner (1979) reported that the Andrus Center counseling program has expanded into the community because of the observation that only a limited number of older persons will come to a university campus for that service.

Another well known program is the Senior Actualization and Growth Exploration or SAGE program. This program started in January, 1974 under the leadership of Gay Luce. It is aimed at helping older persons realize that later adulthood can be one of the most significant and rewarding periods of one's life. By 1976, SAGE leaders were conducting eight groups in four counties in California, and the program has continued to grow and flourish despite very limited funding. A major component of the program is a cluster of activities aimed at deep muscle relaxation. First the body, then emotions, and finally the mind are viewed as benefiting from relaxation exercises. The widespread belief that old people should accept illness, stiffness, and aching joints as part of the aging process and should limit activities and energy output is challenged through this program. An undergirding philosophy of SAGE is that frequently one can change the body and be rid of many ailments if one can change old habits that brought on the aches and pains in the first place. Leaders of the SAGE program sometimes are selected from among older participants on the basis of caring, sensitivity, authenticity, and the ability to listen with sympathy and patience. This program has received national acclaim but has faced ongoing financial problems. The program is free to participants (Elwell II, 1976).

The University of Nebraska Center on Aging conducted a Community Assistants program which provides an example of older persons both as peer facilitators and advocates for community action to better serve older people. Participants in a Senior Companion program and residents of public housing. high-rise apartments were invited to undergo a nine-week training program. Microcounseling training techniques and assertion training were used to help trainees develop counseling skills to be applied in their immediate living environment. In that role Community Assistants were expected to become more concerned neighbors and to facilitate increased independence and autonomy among their peers. They also were expected to help reduce some of the stereotyped behaviors of older persons through their peer role modeling and advocacy counseling (Bolton & Dignum-Scott, 1979).

Another peer counseling program is one developed at CEMREL which provided counseling services at nutrition centers and other locations in the community. CEMREL, Inc., an educational laboratory in St. Louis, received a Quality Improvement grant from the Administration on Aging to develop a model peer counseling program among older persons who participate in programs funded primarily through the Older Americans Act. Older persons who were observed by project staff and student interns in counseling to have high degrees of warmth, genuineness, and empathy and who were reported by peers to be natural helpers in environments such as nutrition centers and high-rise apartments were invited to undergo training to further improve their helping skills. Training focused on three primary goals: preparation in the concepts of counseling/facilitating skills using Carkhuff's approach as the basic model, development of an understanding of the basic concepts of gerontology with a special emphasis on the psychological aspects of aging, and familiarization with the aging network in the St. Louis area. Following training, the peers returned to nutrition centers and high-rise apartments to implement their improved helping skills. A unique feature of this program and one that has been urged for replication was the establishment of linkages or teams consisting of older adult trainees and university counseling students. These teams underwent training together and also worked together in nutrition sites and high-rise apartments (Salmon, 1980).

Information and referral. In order for the vast array of existing community resources to become available to older persons, some entity must perform a facilitative or linkage function. Information and referral (I & R) agencies

are designed to do just that. The extent to which goals are met varies widely. One such service is INFOLINE in Hartford, Connecticut. It is funded with United Way and Title XX (Social Security Act) funds, as are many such programs, and provides services to the community without respect to age (They're looking for trouble, 1981). Other 1& R services, funded with Older American Act funds, target their services specifically to older persons. An example is the Lincoln Information & Referral Service for the Elderly (LIFE) in Nebraska (Hopkins, Note 15). Some I & R centers operate after hours emergency phone lines, often as part of the state mental health network. The I & R service in Gainesville, Florida, operates twenty-four-hour-a-day incoming W A TS lines for a 16-county, largely rural area, and provides both crisis intervention and I & R services. Trained counselors are on call for all of these programs.

A final important function of I & R services is apparent; that is, to point out the services that are needed by members of a given community. Through identifying gaps, I & R programs can facilitate the advocacy process for services to fulfill unmet needs.

Discussion and Recommendations

The programs described in this article provide an indication of the broad range of interventions currently available to meet the mental health needs of older people. Many of these are new programs and represent models for service delivery which may vary in effectiveness when replicated in other areas.

Although it may appear, particularly to the newcomer in gerontological counseling, that numerous gerontological mental health programs exist, this is not the case. Although more programs exist than discussed above, the practice of counseling psychology lags far behind the high incidence of mental health needs of older people. The reader need only refer to the results of the informal survey conducted by the authors to obtain one simple example of the mental health field's lack of commitment to and involvement with older persons.

Paradoxically, a system through which gerontological mental health services could be delivered has been in place for many years. Currently in the United States there are more than 700 community mental health centers which provide an opportunity for the delivery of such services, yet few CMHCs do so. Of those that do have a geriatric component, few are comprehensive, staffed sufficiently, or by properly trained personnel. Often no new personnel were hired to staff and/or direct a geriatric program when one was developed. Rather, too frequently already on board staff, generally with no experience, training, or interest in aging, were reassigned to the geriatric program. In short, while a potentially viable system for service delivery exists, and while some programs have been initiated, the system has not even approximated its potential for reaching older people, and many of the existing programs are inadequately led, staffed, and funded. Under the current block grant system, programs can flourish or falter depending in large part on the advocacy efforts of individual groups concerned about geriatric mental health throughout the nation.

Thus, we have at this time no functioning, comprehensive national system for delivery of mental health services to the older people of this country. No more than a tiny portion of those persons estimated to be in need are reached. At present the mental health and counseling services for older people are accurately described as a hit and miss, non-systematic series of minimally funded, often short-lived projects and programs working in isolation and without stringent or even any evaluation of effectiveness.

In the Report to the President of the President's Commission on Health (President's Commission on Mental Health, 1978), preventive activities were urged in the area of mental health. The 1971 White House Conference on Aging also urged preventive activities, including preretirement counseling. Yet two of the major agencies (AoA and NIMH) that have helped meet the mental health needs of older persons through both preventive and rehabilitative services face significant cutbacks in funding. Although the 1981 reauthorization of the Older Americans Act (P.L. 97-115) in Section 422 (b) includes in nearly verbatim language portions of Section 402 (a) of the Mental Health Systems Act, to date AoA appears not to have funded mental health programs congruent with the intent of this section of the law. At a time of great need, mental health practitioners serving older persons appear to be losing ground, especially with regard to federal and state funding.

Our national failure to provide mental health services for older people is of course self-imposed and subject to reversal. We believe the following briefly stated recommendations represent elements in that process of reversal.

The success and comparative effectiveness of different counseling services must be assumed if the counseling services are to be improved. This is also one of the keys to maintaining or increasing funding. The other key is political action and advocacy based on proven program effectiveness.

Therapists and other existing staff of mental health care systems can be trained to work with older persons. Attempts can be made to help them develop more realistic, less ageist, attitudes toward older individuals. Numerous universities now offer such training, and various continuing education and in-service training programs are available.

Public education about older people should help increase awareness of and responsiveness to the needs of older people on the part of community social services and political organizations. The involvement of therapists as part of the education team could be very beneficial.

Service to older persons may be expanded through a redefinition and expansion of the counselor's role. New roles of advocacy and consultation on the part of counselors can help nonmental health agencies become important links in the mental health service delivery system. Counselors also must assume the role of political advocate to insure that sufficient ADM block grant monies, AoA and other funds are allocated to geriatric mental health programs and services.

Increased outreach efforts seem warranted to ameliorate accessibility problems. More model projects would contribute to our knowledge of approaches that work with specified populations. These projects could include services for special groups such as minorities, families, and so on.

The collation and integration of counseling with other programs can help to link mental health with other social services. This linkage would be fostered through an increased emphasis on emerging settings and alternative approaches to the delivery of mental health care systems. As Cohen (1979-80) states, "The point is not that alternative settings are better than traditional facilities, but that they provide additional options for improving the delivery of community-based care to the elderly" (p. 173).

Despite the inadequacy of programs and lack of a systematic plan for attacking the mental health and counseling needs of older people, we are not without examples of programs worthy of scrutiny and emulation. This article has sought to portray the existing scene by pointing to examples that can serve as stimuli for future development.

Mental health practitioners interested in the needs of older persons rarely have an opportunity to share common concerns. *The Clinical Gerontologist*, a new journal published by Haworth Press, provides a forum for sharing of problems and concerns related to mental health and aging. As a national focal point and information exchange, it is hoped that this journal will help to fill the gaps in our knowledge that affect our training, research, services, and ultimately, older people.

Reference Notes:

1. Krajewski, T. F. *Maryland Department of Health and Mental Hygiene.* Personal communication, 1981.
2. Raschko, R. Personal communication, September 11, 1981.
3. Bertrand, J. A. *Arizona Department of Health Services.* Personal communication, 1981.
4. Roe, L. G. Personal communication, December 6, 1977.
5. Cook, J. Personal communication, 1981.
6. Thibodeaux, A. Personal communication, September 11, 1981.

7. Wasserman, D. Personal communication, June 11,1982.
8. Atkins, J. Personal communication, June 12, 1.981.
9. Campbell, R. Personal communication, 1980.
10. Shearer, R. E. Personal communication, 1980.
11. Green, R. R. Personal communication, December 6, 1977.
12. Housman, R. Personal communication, 1980. 51
13. Huddleston, W. C. Personal communication, 1982.
14. Rosen, S., & Rosen, C. E. *Evaluating an innovative program of preventive mental health services for rural elderly.* Paper presented at Gerontological Society's 31st Annual Meeting, 1978.
15. Hopkins, A. Personal communication, 1981.

References:

1971 White House Conference on Aging. *Toward a national policy on aging. Final Report, Vol. II.* Washington, DC: U.S. Government Printing Office, 1971.

Academy for Educational Development. *Never too old to learn.* New York: Author, 1974.

Adult Day Care Directory. Baltimore: Division of Long-Term Care, Office of Standards and Certification, Health Standards and Quality Bureau, 1980.

Arthur, G., Donnan, H., & Lair, C. Companionship therapy with nursing home aged. *Gerontologist,* 1973,13(2),167-170.

Barnes, E. K., Sack, A., & Shore, H. Guidelines to treatment approaches: Modalities and methods for use with the aged. In M. L. Ganikos (Ed.), *Counseling the aged: A training syllabus for educators.* Falls Church, VA: American Personnel & Guidance Association, 1979, 195-209.

Barnes, J. Effects of reality orientation classroom on memory loss, confusion, and disorientation in geriatric patients. *Gerontologist,* 1974, 14(2), 138-142.

Benight, K. Ideas for placing senior citizens. *NECA Newsletter,* January 1981, 3-5.

Berkman, B. Community mental health services for the elderly. *Community Mental Health Review,* 1977, 2(3), 3-9.

Blackman, D. K., Howe, M., & Pinkston, E. M. Increasing participation in social interaction of the institutionalized elderly. *Gerontologist,* 1976, 16(1), Part 1, 69-76.

Bolton, C. R., & Dignum-Scott, J. E. Peer-group advocacy counseling for the elderly: A conceptual model. *Journal of Gerontological Social Work,* 1979, 1(4), 321-331.

Browne, C. A psychogeriatric day unit. *Nursing Times,* November 4, 1976, 1711-1713.

Buder, R. N. *Why survive?* Being old in America. New York: Harper & Row, 1975.

Caley, B. Outpatient services for the geriatric patient. *Health & Social Work,* 1979, 4(1), 201-210.

Capuzzi, D., Gossman, L., Whiston: S., & Surdam,J. Group counseling for aged women. *Personnel and Guidance Journal,* 1979, 57(6), 306-309.

Clark, B., Wade, M., Massey, B., & Van Dyke, R. Response of institutionalized geriatric mental patients to a 12–week program of regular physical activity. *Journal of Gerontology,* 1975, 30(5), 565-573.

Cohen, G. D. Mental health services and the elderly: Needs and options. In S. Steury & M. L. Black (Eds.), *Readings in psychotherapy with older people.* Rockville, MD: National Institute of Mental Health, 1977 (DHEW Pub. No. (ADM) 77-409).

Cohen, G. D. An alternative setting for community-based gerophychiatric care. *International Journal of Mental Health,* 1979-80, 8(3-4), 173-184.

Colthart, S. M. A mental health unit in a skilled nursing facility. *Journal of the American Geriatrics Society,* 1974, 21(10), 453-456.

Counseling services for older adults. Program #28-08 B, Mental Health. Washington, DC: Social Gerontology Resource Center, 1981.

Department of Health, Education and Welfare, Public Health Service, Alcohol, Drug Abuse, & Mental Health Administration. *Research on the mental health of the aging.* Rockville, MD: National Institute of Mental Health, 1977 (DHEW Publication No. (ADM) 79-379).

Division of Long Term Care. *Adult day care directory.* Baltimore, MD: Office of Standards and Certification, Health Standards and Quality Bureau, 1977.

Donahue, W., Gottesman, L;, & Coons, D. Milieu treatment of older mental patients. In S. Wolock, *An analysis of milieu treatment of older mental patients.* Rockville, MD: Center for Studies ofthe Mental Health of the Aging, 1981, in press.

Elwell II, E. E. The SAGE spirit. *Human Behavior, 1976,* 40-43.

Finkel, S. 1. Psychiatric consultation in a community agency serving the elderly. *Hospital and Community Psychiatry,* 1980, 31(8), 551-554.

Fiscal 82 *proposed budget.* Washington, DC: Association for Gerontology in Higher Education, March, 1981.

Getz, L. H. They're coping with senility. *Modern Maturity,* April-May, 1981, 82-85.

Glasscote, R., Gudeman, J. E., & Miles, D. *Creative mental health services for the elderly.* Washington, DC: Joint Information Service of the American Psychiatric Association and the Mental Health Association, 1977.

Goldstein, S. E., & Carlson, S. Psychogeriatric day hospital. *Canadian Medical Association Journal,* 1976, 15(9), 874-876.

Group for the Advancement of Psychiatry. *The aged and community mental health: A guide to program development.* Volume VIII, Report No. 81, November 1971.

Johnson, C. Older worker employment program: CETA works for older people. *Aging and Work,* 1980, 4(3), 268-270.

Jones, M. *Beyond the therapeutic community.* New Haven, CT: Yale University Press, 1968.

Kerschner, P. A. Programs and environments for counseling older adults: An overview. In Ganikos, M. L. (Ed.), *Counseling the aged: A training syllabus for educators.* Washington, DC: American Personnel and Guidance Association, 1979.

King, S. Counseling the younger elderly-A responsive approach. *Journal of Jewish Communal Service,* 1977, 54(1), 26-31.

Kostick, A. A day care program for the physically and emotionally disabled. *Gerontologist,* 1972, 12(2), 134-138.

Lago, D., & Hoffman, S. Structured group interaction: An intervention strategy for the continued development of elderly populations. *International Journal of Aging and Human Development,* 1978, (4), 311-324.

Lawrence, P. Applying helping skills with special populations. In J. E. Myers (Ed.), *Counseling older persons. Volume III: A trainer's manual for basic helping skills.* Falls Church, VA: American Personnel and Guidance Association, 1981.

Leonard, L. Adult day care centers: A potent force for individual and family change. In S. S. Sargent (Ed.), *Nontraditional therapy and counseling with the aged.* New York: Springer, 1980.

Levy, S. M., Derogatis, L. R., Gallagher, D., & Gatz, M. Intervention with older adults and the evaluation of outcome. In L. W. Poon (Ed.), *Aging in the 1980's: Psychological issues.* Washington, DC: American Psychological Association, 1980, 41-64.

Litwak, E. Research issues in mental health services for the elderly. In *Issues in mental health and aging. Volume III, services,* 1979. (DHEW publication No. (ADM) 79-665).

Lopez, M. A. Social skills training with institutionalized elderly: Effects of precounseling, structuring and overlearning on skill acquisition and transfer. *Journal of Counseling Psychology,* 1980, 27(3), 286-293.

Lutrie, E., Kalish, R. *A.,* Wexler, R., & Amsak, M. On Lak Senior Day Health Center. *Gerontologist,* 1977,16(1),29-46.

McDonald, R. D., Neulander, *A.,* Holrod, 0., & Holcomb, N. S. Description of a non-residential psychogeriatric daycare facility. *Gerontologist,* 1971, 11(4, Part I, 322-326.

Myers, J. E. A national survey of geriatric mental health services. *American Mental Health Counselors Association Journal,* 1982, in press.

NRTAlAARP, AIM. On being alone. Washington, DC: Author, 1981.

Newman, R. S. From isolation to involvement .... A Texas community college welcomes its elderly neighbors. *Counseling and Values,* 1980, 24(4), 247-255.

News & Views. Oklahoma Department of Human Services, March, 1981.

Patterson, R. Community mental health centers: A survey of services for the elderly. *Issues in mental health and aging, Volume III: Services.* (DHEW Publication No. (ADM) 79-665), 26-30.

President's Commission on Mental Health. *Report to the President of the President's Commission on Mental Health.* Washington, DC: U.S. Government Printing Office, 1978.
Radding, N. M. SAGE advocate employment service WHEEE: A program description. *Journal of Employment Counseling,* 1980, 17(1), 28-36.
Reiter, S., Waters, E., Weaver, *A.,* & White, B. *Personal growth for older adults.* Rochester, MI: Oakland University, 1979.
Robins, E. G. Adult day care: Growing fact but still a lucky few. *Generations,* 1981, Spring, 22.
Romaniuk, M., & Priddy, J. M. Widowhood peer counseling. *Counseling and Values,* 1980, 24(3), 195-204.
Ronch, J. L., & Solomon, J. R. An outreach and prevention unit in a mental health center serving the elderly. *Hospital and Community Psychiatry,* 1978, 29(11), 710-711.
Ruffin, J., & Urquhart, P. A comprehensive mental health service in San Francisco. *International Journal of Mental Health,* 1979-80, 8(3-4), 101-116.
Rural elderly need-and get-help. *Innovations,* 1978,_ 5(3), 32-33.
Salmon, H. E. A comprehensive strategy for offering guidance and counseling services to older adults. *Counseling and Values,* 1980, 24(4), 210-217.
Selan, B. H., & Gold, C. A. The late life counseling service: A program for the elderly. *Hospital and Community Psychiatry,* 1980, 31(6), 403-406.
Smyer, M. A., Siegler, I. C., & Gatz, M. Learning to live in a therapeutic community: A study of elderly inpatients. *International Journal of Aging and Human Development, 1976,* 7(3), 231-235.
Special Committee on Aging, U.S. Senate. *Aging and mental health: Overcoming barriers to service.* Washington, DC: U.S. Government Printing Office, 1980.
Steer, R. A., & Boger, W. P. Milieu therapy with psychiatric medically infirm patients. *Gerontologist,* 1975, 15(2), 138-141.
Stein, S. Tucson project aides older job seekers. *NECA Newsletter,* January, 1981.
Thibodeaux, A. They're looking for trouble. *Human Development News.* Washington, DC: U.S. Department of Health and Human Services, May 1981.
V.A. Hospital, Tuscaloosa. *Nursing Service Guide for Reality Orientation.* June, 1970.
Vontress, C. E. Problems in counseling minorities. *Counseling and Values,* 1980, 24(2), 118-126.
Waters, E., Fink, S., Goodman, j., & Parker, G. Strategies for training adult counselors. *The Counseling Psychologist,* 1976, 6(1), 61-66.
Waters, E., Reiter, S., & White, B. Peer counseling for older people. *Educational Gerontology,* 1976, 1(2), 157-170.
Waters, E., Reiter, S., White, B., & Dates, B. The role of the paraprofessional peer counselors in working with older people. In Ganikos, M. L. (Ed.), *Counseling the aged: A training syllabus for educators.* Washington, DC: American Personnel and Guidance Association, 1979.
Waters, E., White, B., Dates, B., Reiter, S., & Weaver, A. *Peer counseling for older people: Final report to Administration on Aging.* Grant No. 90-A-931, 1979.
Weiler, P. G. *Adult day care: Community work with the elderly.* New York: Springer, 1978.
Weinberg, j. Community programs for the elderly: Alternatives to institutionalism. *Issues in mental health and aging, Volume Ill: Services.* Rockville, MD: National Institute of Mental Health, 1979 (DHEW Publication No. (ADM) 79-665), 17-19.
Widowed persons service. Long Beach, CA: *NRTA/AARP,* AIM, 1981.
Wolf, R. S. *A study to determine the relationship between availability of mental health services for the elderly and utilization of long-term care facilities by the mentally impaired.* Unpublished doctoral dissertation, Brandeis University, 1976.