

## A National Survey of Geriatric Mental Health Services

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### **Abstract:**

A survey of states found great variability in services provided to older populations.

### **Article:**

It has been well established that although over 12% of the nation's population is elderly, only 2% to 4% of persons seen in outpatient mental health clinics are in the over 60 age group. Additional inequalities exist with respect to other components of the mental health service delivery system. This situation has continued for many years in spite of legislation, such as the Mental Health Systems Act, intended to effect needed changes. Although the ultimate impact of policy is felt at the local service delivery level, major impetus for programming is often the responsibility of the statewide mental health agency. This article reports the results of a state-by-state survey of mental health services available for older persons and compares the extent of need and existing federal mandates.

### **NEED FOR GERIATRIC MENTAL HEALTH SERVICES**

An estimated 25% of all older persons have depression or some other significant and perhaps treatable mental health problem at any given time (Kramer, Taube, & Redick, 1975). Although most manage to cope adequately with loss and stress, emotional reactions may intensify and become debilitating when not treated. The incidence of psychosis, for example, is known to increase with advancing age and is twice as common among persons over 75 as in those of ages 25 to 34. Persons over age 60 commit 25% of all reported suicides (Special Committee on Aging, 1980).

Some 30% of the beds in public mental hospitals are occupied by elderly persons. A study funded by the National Institute of Mental Health (NIMH) revealed that more than 60% of these persons received no psychiatric care prior to their admission (Select Committee on Aging, 1979). Moreover, at least 50% of elderly persons residing in long-term care facilities are there because of a diagnosis of senility—a treatable and frequently reversible condition (Special Committee on Aging, 1980).

A variety of explanations for the lack of adequate mental health services to the elderly population has been proposed. Cohen (1977) described therapists as reluctant to work with older people, as did Butler and Lewis (1977). The U.S. Senate Special Committee on Aging (1980) conducted a series of hearings on barriers to services and identified a number of key issues. The first problem involves the current reimbursement policies for public and private insurance programs. A second barrier is inadequate training of mental health personnel in the needs of the elderly. Third, there is a lack of coordination among the various service delivery agencies. A major outcome of these hearings was the passage of the Mental Health Systems Act (PL 96-398, 1980). This act represented a significant effort to further the provision of mental health services to all persons throughout the nation who might need them. It reflected a recognition by Congress that, in spite of progress made in the mental health movement, both unserved and underserved populations still exist. Furthermore, it specifically targeted "certain groups in the population, such as ... elderly individuals ... [who] . . . often lack access to adequate private and public mental health services and support services" (Section 2).

It is important to note that federal mandates to provide mental health services to older people existed prior to the passage of PL 96-398. The extent of underservice by community mental health centers provoked the passage in 1975 of PL 94-63, known as the Community Mental Health Centers Amendments, which required all federally assisted centers to provide care for older people equal to that for persons of other ages (Patterson, 1979). It is the responsibility of state mental health agencies to ensure the implementation of these federal mandates. With this background of need and service delivery in mind, the present study was undertaken to determine the current status of statewide planning for mental health services to older people.

## **METHODOLOGY**

A request for information was sent to the officially designated authorities of each state (n=50) and territorial (n=6) mental health program, as identified by NIMH. Each state was asked to submit program descriptions and any other available information on their mental health gerontology programs. The open-ended format of the request indicated that each state office was being asked to provide information concerning their programs and provisions to meet the mental health needs of older people. Participation was encouraged by involvement of APGA's National Project on Counseling Older People in the data collection effort.

The original mailing specified a deadline for submission, allowing each state 30 days to respond by mail or telephone. A follow-up note was sent 2 weeks later as a reminder of the nature and purpose of the survey and to encourage responses. The possibility of a follow-up telephone call to nonrespondents was considered as a means of increasing the overall rate of response. This idea was rejected, however, in an attempt to maintain comparability of data received. The information that would have been provided to each nonresponding state through such a call would have exceeded that given to other respondents. It also would have eliminated the voluntary nature of participation, which is a significant factor, especially if one assumes that most states having services for older people would respond to a request, such as the one in this study, from a national organization seeking to include their programs as resources for training and services.

## **RESULTS**

The request for information and follow-up note yielded a total of 27 responses from the 56 states and territories surveyed (48%). This included 25 mailed responses and 2 telephone conversations. A summary of the responses is provided in Table 1.

Column 2 of this table shows that 14 of the states reporting (52%) provide mental health clinic or outpatient services specifically for older people. Another 6 states (22%) provide clinic services to the general public, with services to older persons included but not specifically provided or not provided in a separate clinic setting. The remaining 7 states (26%) did not report having clinic services available for older people.

A review of the third column of Table 1 shows that 9 states (33%) provide hospital or inpatient services specifically for older people, one state provides such services to the general public, and 14 states (52%) failed to report specific inpatient services for older people.

Eleven states (41%) reported having other specific services for older people, including model and demonstration projects and cooperative endeavors with other community agencies. Several states reported having strong working relationships with their respective state aging program offices. In fact, one state mental health officer referred the author to the aging program office for any information because his or her office provided no services for older people.

**TABLE 1**  
**States Providing Geriatric Mental Health Services**

State	Services		
	Clinic*	Hospital*	Other*
1. Alabama	+	0	0
2. Alaska	+	0	0
3. California	+	+	+
4. Colorado	=	0	0
5. Connecticut	0	0	+
6. Delaware	=	+	+
7. Georgia	+	+	+
8. Guam	0	0	+
9. Indiana	+	=	+
10. Iowa	0	0	=
11. Kansas	+	0	0
12. Maryland	+	0	+
13. Massachusetts	0	0	0
14. Missouri	0	0	0
15. Nebraska	+	0	+
16. New Jersey	=	0	0
17. New Mexico	=	0	0
18. New York	+	+	+
19. Ohio	+	+	0
20. Oregon	=	0	0
21. Rhode Island	0	+	0
22. South Carolina	0	+	0
23. Tennessee	+	+	0
24. Texas	=	+	+
25. Virginia	+	+	+
26. Washington	+	+	+
27. West Virginia	0	0	0

\*The following symbols are used in this table:

- = Provides mental health services to the general public, including reference to older people
- + Provides mental health services specifically for older people
- 0 No report available of any mental health services specifically designed to meet the needs of older people

Five of the states that responded (19%) reported providing special clinic and hospital services for older people, as well as other services specifically designed to meet the mental health needs of older people. Three states (11%) did not submit any report of services specifically designed for this population.

There was also a wide variety in the types of delivery systems reported. At one extreme were a few states that provided an overview of their total mental health system with remarks that generally indicated that older persons were served in that system. Others indicated, somewhat vaguely, that older persons were served "according to their need" in all of the states' mental health programs. Many reported that some elderly persons were seen in outpatient clinics; however, most older people were treated in inpatient care settings that primarily involved long-term care rather than short-term hospital stays.

The availability of other programs to serve elderly persons was usually contingent upon the availability of special funds, notably from NIMH. Some of the special programs attempted statewide coverage of mental health needs of older people and others provided regional, multicounty, single county, or city model or demonstration programs. Several of these programs have been described in detail elsewhere (see Myers & Salmon, in press). Because the purpose of this article is to provide an overview of the national service delivery network, specific program descriptions are not included here.

## DISCUSSION

The response rate of 48%, although not unusual for mail surveys, does limit the range of conclusions that may be reached from the available data. The services provided in the states that did not respond may differ in unknown ways from those that did reply to the survey request.

As mentioned earlier, extensive follow-up efforts were not conducted because they would have biased the data by eliminating the factor of voluntary participation. Perhaps a future study, designed without this factor, could elicit a greater range and variety of data. A more extensive questionnaire than that used in this study would be required. The questionnaire would also serve as a structured interview format for any follow-up telephone calls. The open-ended format of the questions asked in this study is reflective of the pilot nature of the data collection effort. The range and nature of responses received do, however, permit some interesting speculations and discussion.

Of primary interest is the finding that the congressional intent to serve older people, exemplified in several legislative mandates, is not being fully implemented throughout the states, nor is there much uniformity in implementation procedures. The low priority assigned to the older population in many states virtually ensures that these mandates will not be implemented to any great extent. Perhaps the flow of priorities is not well communicated from the national level to the states. Or perhaps each state maintains its own list of service priorities, subject to available resources.

It was not the purpose of this article to explore reasons for the present situation, although funding obviously seems to be a major issue in program design. The results raise two questions: (1) exactly what services are being provided to older people, and (2) how comparable are these services across states and geographic regions. Certainly, we cannot achieve maximum improvement in the overall service delivery system until we know the extent of current service provision. Additionally, it would be useful to know more about the procedures for state interpretation and implementation of federal mental health priorities. Perhaps the major outcome of this study is the recognition of a need for further research to examine the full national scope of mental health care. Such information would surely prove useful to those who set national policy as well as those who implement it at all levels.

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