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Descriptive Analysis of the Elderly Who Utilize Mental Health Services With Implications for Program and Policy Development

Timothy P. Mahoney

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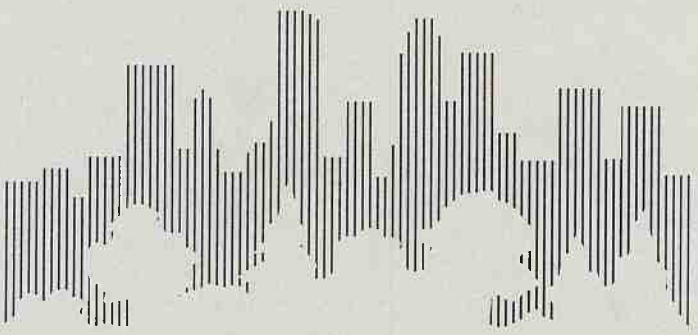

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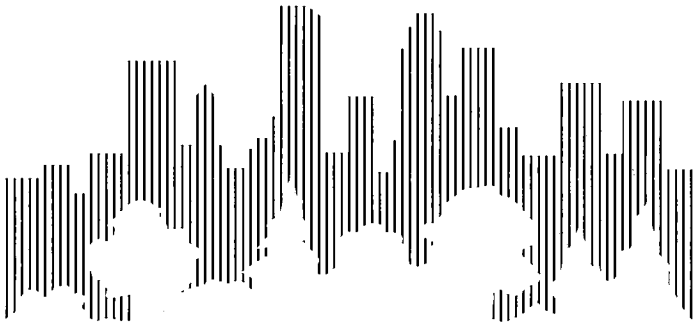

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Descriptive Analysis of the Elderly Who Utilize Mental Health Services With Implications For Program And Policy Development

by

Timothy P. Mahoney

A Thesis
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MASTER OF SOCIAL WORK
AUGSBURG COLLEGE
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CERTIFICATE OF APPROVAL

This is to certify that the Master's thesis of:

Timothy P. Mahoney

has been approved by the Examining Committee for the thesis requirements for the Master of Social Work Degree.

Date of Oral Presentation: April 11, 1996

Thesis Committee:

Thesis Advisor, Sharon Patten, Ph.D.

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Thesis Reader, Deb Carlsrud, M.S.W.

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ABSTRACT OF THESIS

A Descriptive Analysis of the Elderly Who Utilize Mental Health Services With Implications for Program and Policy Development

Timothy P. Mahoney

April 11, 1996

The utilization of mental health services by community-dwelling elderly is examined in this study. The number of elderly in the U. S. population is increasing significantly and is projected to continue to do so for the next 40 years. Literature indicates that the mental health component of services for the elderly is strikingly underdeveloped and underutilized. Past research suggests that factors influencing this low level of service development and utilization can be found in the characteristics of the population as well as in the characteristics of the mental health care system.

In this study, data were collected on 62 elderly persons aged 60 and over who received services in a rural community mental health center in southeast Minnesota. Demographic and psychiatric characteristics are summarized from a medical records review. Characteristics of the mental health care system and issues pertinent to program planning for this population are presented, including a historical examination of service delivery, barriers to mental health care, and factors that contribute to mental health services that are more responsive and more utilized.

From the study sample of 62 persons, 56% were diagnosed with mood disorders, 14% with psychotic disorders and 8% with chemical dependency. A majority of the sample were in the 60-70 year age range (52%), 66% were females and 52% of the clients relied on others for transportation to mental health services.

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Chapter I Introduction

Since the 1960's, community mental health centers have been involved in the deinstitutionalization movement for those with mental illnesses by providing community-based mental health services. This research project is about a sub-population of those with a mental illness, the community-dwelling elderly. Further studies of this target population are warranted because of the well documented underutilization of services in the community mental health sector and the rapidly growing number of individuals who constitute the elderly segment of the U.S. population. The implications of this growth is summarized in the following statement by Brock, Guralnik & Brody (1990) :

> Since the beginning of the twentieth century, the older population of the United States has experienced a ninefold increase in numbers and a tripling of the overall proportion of older persons. Along with this growth in population size, the length of life of older people has increased and with it the burden of morbidity and disability. (p.21)

The number of people with mental disorders among the elderly will increase as a result of the rapid population growth. Literature indicates there is a lack of specialized formal geriatric mental health services to meet the needs of this segment of our population (Waxman, Carner & Klien, 1984).

Many factors contribute to the lack of specialized services including: undiagnosed and untreated mental disorders (Buckwalter, Abraham, Smith & Smullen, 1993), lack of aggressive outreach and case findings in mental health service programs (Lebowitz, 1988), stigma associated with aging and mental health (Wehry, 1990), and underutilization of services by the elderly due in part to self-determination and autonomy (Raschko, 1985).

During the 1960's community mental health centers were designated as key service providers to implement the deinstitutionalization movement for

those suffering from a mental illness. Underdevelopment and underutilization of community mental health services for and by the elderly have been well documented (German, Shapiro & Skinner, 1985; Lebowitz, 1988). Past research suggests that factors influencing this low level of service availability and utilization can be found in characteristics of the population as well as characteristics of the mental health care system.

Mental health care system characteristics that create barriers are cited in the literature by Butler, 1969; Colenda & Dooren, 1993; Eisdorfer, 1989; Lebowitz, 1988; Raschko, 1985; include the following:

1.) Fragmented, disorganized systems of health and social services available to the elderly
2.) The limited availability of transportation services and other problems involving accessibility
3.) Continued ageism, or negative attitudes toward aging and the aged, on the part of mental health and health professionals
4.) Inequitable reimbursement structures of federal health-care programs and other financial barriers
5.) The low number of mental health professionals who are interested in and trained to provide care to the elderly
6.) "Turf-guarding" by agencies seeking to protect their share of reduced resources

Characteristics of the elderly which prevent them from utilizing mental health services according to Waxman (1984) include the following:

1.) Generational attitudes regarding mental illness and its causes
2.) An unwillingness to reveal symptoms such as forgetfulness or confusion for fear of institutional placement
3.) Professional help may not be sought because problems are simply not seen in psychological or psychiatric terms
4.) Perceived stigma attached to seeking help for these kinds of problems, or the belief that mental health professionals have little help to offer for the problems that they are enduring
5.) Family members may contribute to underutilization by refusing to admit that their elderly relative may have a psychiatric disorder

Terms and Definitions

For the purposes of this research study, the definition of elderly will vary depending on the study cited or data presented. Some studies considered persons 60 and older as elderly and other studies used 65 and older to define the elderly. The age criteria used will be designated. Community-dwelling elderly will refer to individuals who are residing in the community and not receiving 24 hour supervised care by formal care providers, e.g., nursing homes, residential treatment centers. Community mental health services will consist of any service provided by a licensed psychiatrist, psychologist, social worker or paraprofessional supervised by one of the above professionals. Psychiatric characteristics and mental disorders will be defined by clinical diagnosis criteria in the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994). Demographic characteristics will include age, sex, ethnic background, marital status, living site, and living arrangements.

History of Zumbro Valley Mental Health Center

The beginning of what is currently Zumbro Valley Mental Health Center (ZVMHC) originated in 1947, in Rochester, Minnesota. Returning World War II veterans who were struggling with emotional and psychiatric disabilities were in need of mental health services. A loose arrangement was made in which those who were qualified to provide services were introduced to those seeking services on a voluntary basis with no funding involved. This type of arrangement lasted for two years, at which time, federal grant dollars and community monies were sought to continue services. Eventually, paid staff consisted of a psychiatrist, a psychiatric social worker and a part-time secretary.

Purpose of this Research Study

Literature indicates the best clinical outcomes are achieved when specific target populations are identified and treated (Colenda & Dooren 1993). Data have been gathered on some of the characteristics of service recipients at Zumbro Valley Mental Health Center-Red Wing Unit, but no analysis of the elderly as an exclusive target population has been conducted. This research study explored the demographic and psychiatric characteristics of elderly persons age 60 and over who received mental health services during a one year period at the Red Wing Unit.

Data gathered were used to complete a descriptive analysis of the community-dwelling elderly who have received services at this unit. This information will provide a basis upon which planning can take place in an informed atmosphere and contribute to the understanding and design of mental health services for this target population. Profiling those who have received services is a critical component for the purposes of need assessment, program planning and evaluation. It is essential to know and understand precisely who it is we are serving and specifically what problems they are experiencing. These issues are understood on a case by case basis by each practitioner, but no summative computation has been completed to provide an overall profile of those served at the Red Wing Unit.

Research Questions

This research study will address the following three questions:

1.) What are the demographic and psychiatric characteristics of elderly persons, age 60 and older, who have utilized mental health services at the Zumbro Valley Mental Health Center-Red Wing Unit, during a one year period?

2.) What is the projected number of people aged 65 and older who are in need of mental health services in Goodhue county?

3.) Based on the results of this research and utilization of a planning process: What are the recommendations for future programming to better address the needs of this under served population?

Chapter II Literature Review

Overview

A review of the literature was conducted in four major areas for the purpose of this research study. First, a historical review of service delivery to those suffering from a mental illness is provided. Second, current and projected population trends of the elderly are examined. Third, demographic and psychiatric characteristics are discussed. Fourth, practice methods utilized in community mental health settings to address the mental health needs of the elderly are identified and explained. Also, factors influencing the utilization of mental health services are examined. Different types of mental illnesses common to the elderly are presented including cognitive, mood and psychotic disorders. Prevalence rates, diagnostic criteria and treatment options for the above disorders are provided. Innovative methods of community-based mental health services that have a positive impact on service utilization are identified and discussed.

History of Community Mental Health Centers and Community Support Programs

Historically, people suffering from chronic mental illness were removed from their home and community and placed in state institutions due to inadequate treatment alternatives at the community level. These institutional settings became human warehouses for people with a mental illness. Once admitted, many stayed for extended periods of time, resulting in overcrowding with an emphasis on custodial care versus treatment. Chu & Trotter (1974) summarize the state hospital settings in the following manner:

> started in reaction to the practice of locking up the poor and mentally disturbed in decaying county jails, poorhouse, and blockhouses, the state hospital system was established to ensure more humane treatment of society's cast off's. These new institutions were strongly advocated from the beginning by all the 'enlightened' professionals of the day. But little thought was given to the consequences of creating 10,000 - 15,000 bed cities of the 'mad'; and there was no flexibility for change once the hospitals were found not to provide the most ideal setting for patients. Instead of offering humane and effective treatment of the mentally ill, state hospitals became another enormous bureaucracy catering to vested interest and embodying worse care and societal stigma. (p.203)

Grob (1983) indicates that the number of patients in state mental hospitals between 1903 and 1950 increased by 240 percent (from 150,000 to 512,500).

It was not until the mid-1950's when several factors seemed to have converged, providing the impetus for community- based mental health services. During the late 1940's through the early 1960's a spate of investigative articles appeared drawing public attention to the often shameful conditions existing in mental institutions across the country. Secondly, with state hospitals at their peak populations in the mid-1950's, individual states were becoming acutely aware of the financial burdens in supporting such a system. Finally, and perhaps most importantly, truly effective antipsychotic drugs were becoming available for the first time. Many patients previously regarded as virtually hopeless could now enjoy a far greater degree of symptom stabilization if not remission.

The concept of community mental health care, promoted by the Joint Commission on Mental Illness and Health, became the "bold new approach" adopted by President Kennedy in the Community Mental Health Centers Act of 1963 (Morrissey, 1984). This act provided 150 million dollars in matching grants to provide for psychiatric services at the local level. Since then there has been a national movement toward deinstitutionalization.

This landmark piece of legislation recognized the need to emphasize different services according to the distinctive needs of each local area (rural vs. urban areas, children vs. geriatric populations, etc.). Though comprehensive community mental health centers were initially intended to serve the full spectrum of clientele, it was the plight of people with a chronic mental illness confined in large institutions which most contributed to the creation of these facilities. Many observers including (Reinehr, 1975; Chu & Trotter, 1974; Finkel, 1976) have accused mental health centers of not fulfilling the role for which they were intended, instead catering primarily to the "worried well" rather than giving priority to the severely ill.

In response, the National Institute of Mental Health (1980) established the Community Support Program (CSP) in 1978 "to improve services for one particularly vulnerable population--adult psychiatric patients whose disabilities are severe and persistent, but for whom long-term skilled or semi-skilled nursing care is inappropriate" (p.2). This program established direct care and rehabilitation services for persons with mental illness.

Community Support Programs exist in almost every state as a result of this initiative. There is a wide variety of program models, treatment strategies and techniques being used in the provision of these services. Services are designed to help consumers function in a community setting with as much self-

sufficiency as their capabilities will allow. The overall objective is to promote recovery, and to help consumers function and maintain in a community setting.

In Minnesota, the creation of locally based services can be traced to the state's Community Mental Health Centers Act of 1957. This act established clinics across Minnesota which provided outpatient services on a sliding fee scale. Unfortunately, the centers were severely underfunded. In 1985 a Governor's Mental Health Commission was appointed to review the status of mental health services in Minnesota. In February 1986, it concluded in its final report "Mandate for Action" that "The system of mental health services in Minnesota is divided, inconsistent, uncoordinated, undirected, unaccountable, and without a unified direction" (Report to Legislature, 1987, p.6).

In March of that same year Minnesota was ranked 37th among the fifty states by the Public Citizen Health Research Group for its services to individuals with severe and persistent mental illness. In the 1987, the state legislature responded to the criticism by passing the Minnesota Comprehensive Adult Mental Health Act (CAMHA,1994) . This law mandated that all counties in Minnesota 1.) develop a plan for providing affordable local mental health services and 2.) provide case management and coordination of services for individuals suffering from serious and persistent mental illnesses. Each county had to directly provide or contract through vendors to provide the following range of services:

- Education and prevention
- 24 hour emergency service
- Outpatient services
- Residential treatment services
- Community support program services
- Acute care hospital inpatient treatment services
- Regional treatment center inpatient services

Psychiatric Characteristics

Cognitive Disorders

Cognitive decline is the decreasing ability to learn new information and recall old information and is characterized by demonstrative impairment in short and long term memory, abstract thought, judgment, language, spatial or temporal orientation, and/or adaptive behaviors. Cognitive impairment in the elderly may be over looked because of the tendency to attribute cognitive decline to the normal aging process. Two common forms of cognitive impairment in late life are dementia and delirium.

Dementia is not a single disease, but is a clinical syndrome caused by specific illness that effect the brain. In the American Psychiatric Association (1994), diagnostic criteria indicate the symptoms must be of sufficient severity to interfere with work, social activities, or relationships with others. Symptoms include impaired ability to communicate (aphasia), difficulty executing purposeful movement (apraxia), lack of ability to recognize familiar objects (agnosia), and decline in ability to interpret the visual environment (visual spatial integration).

Psychiatric symptoms accompany dementia illnesses in over 75 percent of cases (Manhiemer, 1994). These symptoms include agitation, depression, hallucinations, delusion, paranoid behavior, combativeness, wandering, excessive vocal behavior, disrupted sleep patterns, rummaging, pillaging and hoarding, and socially or situationally inappropriate behaviors such as public sexual activity and disrobing.

Table 2. Causes of Disorders of Cognition in the Elderly

Potentially reversible causes	Irreversible/progressive cause
Infections of the central nervous system	Alzheimer's disease
Metabolic disorders	Multi-infarct dementia
Intoxication	Parkinson's disease
Depression	Huntington's disease
Brain tumors	Pick's disease
Nutritional deficiencies	Progressive Supranuclear Palsy
Normal pressure hydrocephalus	

Manhiemer (1994)

Dementia is an insidious process in which mental functioning declines over a period of months or years. Symptoms usually do not accelerate rapidly. Some dementia can be reversible, others are irreversible (see Table 2).

No specific diagnostic test for dementia exists. A thorough history from the subject and other informants is crucial to assess if the dementia is reversible. Other diagnostic indicators should include: a listing of all drugs taken including prescription, nonprescription medications and recreational substances, a physical exam, mental exam including standardized cognitive tests and laboratory evaluations including urinalysis, blood chemistry tests and electrocardiogram and brain imaging (computerized tomography scanning (CT scan).

Dementia can be degenerative, vascular, or both. It can be classified as cortical or subcortical. Alzheimer's disease is the most common degenerative form of dementia. Approximately four million people, over the age of 65, in the United States are affected by the disease (Manheimer, 1994). Manheimer further states the highest prevalence is among those over age 85 (47.2 percent) and that by the year 2000 one out of three people age 80 will have significant cognitive impairment, resulting in dementia.

Causes of Alzheimer's disease are not definitive, but research suggests that there may be multiple causes including genetic factors, environmental toxins and viral illness (Manheimer, 1994; Wehry, 1994).

Multi-infarct dementia (MID) is the most common vascular form, sometimes distinguished from Alzheimer's type by its earlier age of onset, more abrupt onset, step wise deterioration, and the patient's previous hypertension. Both Alzheimer's and multi-infarct are cortical dementias. Subcortical dementias are seen in association with Huntington's disease, Parkinson's disease and other movement disorders involving the extrapyramidal tract (Wehry 1994).

Treatment of cognitive impairments usually involves behavior management techniques and medication management to assist with the problem behaviors associated with the illness (psychotic behaviors, anxiety, sleep disturbance, depression, wandering and excessive vocal behaviors). Behavioral therapy is primarily used to help the individual maintain self-control by modifying the environment and changing patterns of social interaction. Specific techniques for cognitive impairment might include: daily schedules, prominent display of clocks and calendars, written directions, checklists, and prominent labeling of commonly used items. Constructive activities might include: listening to music, watching television, reading the newspaper, doing household chores, physical exercise and structured social events.

To address the increased likelihood of insomnia, behavioral techniques might include: restricting late evening fluid intake, especially beverages with alcohol or caffeine, increased physical activity during the day and decrease in the frequency and length of naps. If these interventions are not enough, medications may be required.

Symptoms of wandering can be problematic and dangerous for the client. Attempts to appropriately structure the environment should be made. These changes might include: a well lit room or fenced in yard, installation of more complex locks to limit access to unstructured areas and/or disguising doors by covering with a sheet or mirror, may help decrease wandering behavior. As the disease progresses walking instability may require more attention to environmental hazards and aids to improve stability implemented.

Urinary and fecal incontinence usually occurs later in the progression of the disease and behavioral measure might include: toileting at regular intervals, use of a chart to identify patterns of incontinence and use of bedside toilets. Any signs of infection should be evaluated by a physician.

Medication management may be required in conjunction with behavioral management. If the client is exhibiting psychotic behaviors (hallucinations, delusions, paranoia) or is combative or violent, medications called neuroleptics (e.g., Thorazine, Haldol) are commonly used to treat these symptoms. These medications can cause significant side effects that include: muscle stiffness, slow movement, rigidity, shuffling gait and increased confusion. Long term use may cause a permanent movement disorder called tardive dykinesia. This disorder consists of excessive uncontrolled muscular movements, mainly of the tongue, mouth or extremities.

Dementia can have a devastating effect on family members, who most frequently are the caregivers for those with dementia, especially during the early processes of the disease. Kerrini & Kerrini (1989) discuss how those with dementia are cared for at home, usually by a spouse or daughter. They further explain how these caregivers suffer from poor physical and mental health due to the consistent demands and disturbances associated with caring for a person

with dementia. Mental health therapy and other supportive services outside the family can be of assistance to help cope with feelings of grief, guilt, and anger; to educate about the disease and to provide referrals to community resources that provide respite and peer support. A study by Scott, Roberto & Hutton (as cited in Kerrini & Kerrini, 1989) demonstrated that mental health support of the family led to increased ability of the caregiver to cope more effectively with caring for the family member with dementia.

Delirium

Whery (1994) explains "a person with a delirium may be agitated and display fear, anxiety or depression or be withdrawn, stuporous and mute." The American Psychiatric Association (1994) uses the following diagnostic criteria for delirium:

1.) disturbance of consciousness with reduced ability to focus, sustain, or shift attention.

2.) a change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a preexisting, established or evolving dementia.

3.) the disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.

4.) there is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition.

Causes of delirium include:

1.) primary cerebral disease (infection, cancer, trauma, or stroke)

2.) metabolic disturbances

3.) intoxication, from prescription medications, over the counter medications, recreational drugs or poisons

4.) withdrawal from substances (e. alcohol, sedatives or hypnotic medications)

Diagnosing delirium can be difficult in older persons due to similar symptoms with other disorders, or when super-imposed with other disorders,

particularly dementia (Patten, 1990). Treating delirium is usually successful by figuring out what the underlying cause is and appropriately treating it. Due to the high consumption of medications by elderly, drug misuse and/or adverse drug reactions are common and can be the cause of psychiatric symptoms such as delirium (Whery, 1994). Many adverse drug reactions are ignored or overlooked because they are viewed as part of the normal aging process. Adverse effects include gastrointestinal disturbances, confusion, depression, loss of appetite, weakness, lethargy, unsteady gait, forgetfulness, tremor or constipation (Ferrini & Ferrini, 1989).

Mood Disorders

Specific mood disorders discussed in this review include major depression and bipolar disorder. Prevalence of depressive disorders among community-dwelling elderly varies significantly in the literature. The lack of uniformity is due in part to different criteria and methods of data collection. Differences in measuring prevalence included clinical v.s. non- clinical interviewers, self-reports of depression v.s. DSM III criteria, waiting lists for services etc. Blazer and Caine (as cited in Wehry,1994) conclude that depressive disorders decline with age but depressive symptoms increase with age and are present in approximately 15 % of community-dwelling elderly. Blixen (1988) concluded after a synthesis of the literature on the epidemiology of depression that about 4.4% of older adults suffer from a major depression. Based on surveys of community dwelling elderly, Manheimer (1994) reported that major depression is found in 1-2 % of individuals over age 65. However, Manheimer reports, about 15% of the elderly have a significant degree of depressive symptoms (dysphoria), to the extent that it impairs function. Blazer

(1987) surveyed 1000 community-based older adults and found that approximately 15% reported significant dysphoria and that there was a 1.8% prevalence rate of a primary depressive disorder.

These depressive symptoms may be brought on by medical disorders, physical illnesses, function disability and/or cognitive impairments, which tend to increase with age. Another late life psychological stressor that contributes to depression, is coping with loss. Loss issues are a central theme for many in late life and come in many forms. Such losses include: loss of physical functioning (e.g., mobility, sensory perception, self care skills); loss of social interaction with family, friends and neighbors; loss of achievement or being needed due to retirement from work; loss of spouse or close friend due to illness or death.

Major Depression is defined by The American Psychiatric Association (1994) as a depressed mood or loss of interest or pleasure for more than a two week period and represent a change from previous functioning and is accompanied by at least three or more of the following:

1.) significant weight loss or gain or decrease or increase in appetite nearly every day.
2.) insomnia or hypersomnia nearly every day.
3.) psychomotor agitation or retardation nearly every day.
4.) fatigue of loss of energy nearly every day.
5.) feelings of worthlessness or excessive or inappropriate guilt nearly every day.
6.) diminished ability to think or concentrate, or indecisiveness, nearly every day
7.) recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Diagnostic criteria for Bipolar Disorder, Mixed Episode according to The American Psychiatric Association (1994) includes:

symptoms of major depression followed by symptoms of mania or vice versa. A manic episode consists of an abnormally and persistently elevated, expansive or irritable mood lasting at least one week and three or more of the following symptoms have persisted and have been present to a significant degree.

1.) inflated self-esteem or grandiosity.

2.) decreased need for sleep.

3.) more talkative than usual or pressure to keep talking

4.) flight of ideas or subjective experience that thoughts are racing.
5.) distractibility
6.) increase in goal-directed activity or psychomotor agitation.
7.) excessive involvement in pleasurable activities that have a high potential for painful consequences.

The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others or there are no psychotic features.

Depression can occur in the context of bereavement or adjustment to a significant change or be the manifestation of an underlying physical illness or result from prescribed or over the counter medications (Manhiemer, 1994)

Treatment for mild to moderate forms of depression can be effective using cognitive behavioral therapy without the need for medication. For more serious forms of depression a combination of psychotherapy and psycho-pharmacologic interventions are needed. Psychotherapy is used to clarify the psychological and cognitive distortions that arise as a result of the depression. Pharmacologic interventions help normalize the biological changes in the brain that occur with depression.

Antidepressant medications most commonly used are the cyclic antidepressants, monoamine oxidase inhibitors (MAOIs), antidepressant fluoretine (Prozac) and buproprion (Wellbutrin). Of the older antidepressants, Nortriptyline (Pamelor) and desipramine (Norpramin) tend to have lower anticholingergic side effects and better tolerated by the elderly. Anticholinergic side effects (central nervous system effects) consist of dry mouth, blurred vision, constipation, urinary retention; agitation or sedation.

Another form of treatment for severe depression is Electroconvulsive Therapy (ECT). ECT as described by the National Institute of Mental Health (1985) consists of a brief electrical shock applied to the head by an electrode to

produce a generalized seizure. The treatment regimen usually consists of six to twelve treatments given two to three times a week while the person is anesthetized. The patient is generally prescribed antidepressant medication to reduce relapse. The treatment may cause short-term and long-term memory deficits depending on the number of treatments and placement of the electrodes.

The risks associated with undiagnosed and untreated depression can be devastating. "Suicide rates in those over 65 declined after World War II until the 1980's; now the rate for older adults is increasing. The suicide rate for white males over the age of 70 is highest of any group. In addition to being male, white, and over 70, a number of other risk factors have been identified. These include alcohol abuse, living alone without perceived social supports, the presence of psychosis, and physical illness" (Whery, 1994, p.8). The need to do a thorough assessment of suicide risk is apparent when working with elderly clients who suffer from depression, especially older, white males.

Psychotic Disorders

Psychotic disorders are characterized by delusions, hallucinations, thought disorder and bizarre behavior, indicating a loss of reality. Specific diagnoses described include: Schizophrenia, Schizoaffective Disorder, Delusional Disorder, and Psychotic Disorder Due to a Medical Condition.

Schizophrenia as defined by The American Psychiatric Association (1994) include the following symptoms:

1.) delusions
2.) hallucinations
3.) disorganized speech (e.g. frequent derailment or incoherence)
4.) grossly disorganized or catatonic behavior

Additional findings in the study indicate that unspecialized centers had, without exception, the fewest types and amount of direct and indirect services; and locations of service delivery sites. Specialized centers reported the provision of direct services in other localities including nursing homes, senior centers, senior housing, nutrition sites and community residential facilities in addition to the CMHC location. Indirect services included program and case consultation; consultation with caretakers, advocacy and education; and inservice training.

Based on findings of this study, it is apparent that centers which make a commitment to provide specialized elderly services by specially trained staff have a higher rate of service utilization than centers that do not. Factors cited in efforts to make a determination as to provide specialized community mental health services included: funding streams, population changes, legislative mandates, state/county priority setting and staff interests.

Case Finding

Due to the stigma and symptoms associated with mental illness, rarely do those suffering with mental problems readily accept their condition and seek out treatment. This denial and resistance to intervention may be generated by feelings of shame, suspicion of "the system", fear of losing control over one's life, or fear of forced institutionalization (Raschko, 1990). The result of such feelings, often times for the elderly, is isolation and untreated illness.

Colenda and Dooren (1993) state that the best clinical outcomes emerge when target populations are identified and treated. They define a target population of psychosocially at-risk elderly as those who lack adequate support systems and are functionally and cognitively impaired with psychiatric problems. This population of very isolated, frail elderly rarely seek out services

Chapter III Methodology

Overview

This chapter describes who the subjects of this research study were, the source(s) of the data and the data collection methods. The different variables examined and contained on the data form will be presented and operationally defined. The requirements needed to access the data and issues of confidentiality and consent are presented. A brief description of the three programs from which the data was collected is presented. In addition, the methodology for research question # 2, determing the number of elderly in need of mental health services for Goodhue county will be presented. Discussion of research question #3 will be presented in Chapter VII under the Implications and Recommendations Section.

The research questions of this study include the following:

> 1.) What are the demographic and psychiatric characteristics of elderly persons, age 60 and older, who have utilized mental health services at the Zumbro Valley Mental Health Center-Red Wing Unit, during a one year period?
>
> 2.) What is the projected number of people aged 65 and older who are in need of mental health services in Goodhue County?
>
> 3.) Based on the results of this research and utilization of a planning process: What are the recommendations for future programming to better address the needs of this under served population?

To address research question #1, this study utilized a retrospective medical records review in order to characterize clients, aged 60 and older, who received mental health services at the Zumbro Valley Mental Health Center-Red Wing Unit (ZVMHC-RW). Characteristics examined included socio-demographic

and psychiatric variables. Other variables of interest that might influence utilization or accessibility to mental health services were also examined (e.g., transportation, case management).

Study Sample

The sampling technique used to draw the sample consisted of a single-stage cluster sampling. Subjects were identified from a list of clients who had received services at Zumbro Valley Mental Health Center-Red Wing Unit (ZVMHC-RW) using age and a one year time frame as the criteria for selection. Subjects consisted of all community-dwelling individuals age 60 and older as of October 1, 1994, who received mental health services at the ZVMHC-RW between October 1, 1994 and September 30, 1995. The researcher anticipated that this frame would include enough cases to be representative of the elderly population who utilize services from ZVMHC-RW.

Instrumentation

For the retrospective medical records review, a records abstraction form was developed by the researcher (see appendix A). The final version of the abstraction form consisted of 15 variables with the majority being at the ordinal level of measurement. Substantive areas on the form include demographic and clinical characteristics, social support network, means of transportation, and whether case management services were being provided at the time of referral.

An attribute of the variable living site is the term Supportive Care Residence, which refers to a living site that provides some form of assistance to the resident. In this study, those living sites consisted of foster homes and board and lodging homes. In these situations, the resident remains semi-

information was not located in the records, the primary therapist was asked to provide the missing data, if possible. Responses provided were coded on the data form.

Agency Approval / Confidentiality / Consent

In planning this research study, two hurdles concerning the data collection process had to be overcome. First, was getting approval from Zumbro Valley Mental Health Center administration. Approval was granted provided confidentiality of the clients was protected and there was a signed consent form by the client allowing review of the medical record (see appendix B) . For a review of the consent form see Appendix C. Both of these conditions were met.

Program Descriptions

Three distinct program services are utilized by the elderly population at ZVMHC-RW. They include psychiatric services, out-patient services and supportive outreach services provided by the Community Support Program. Psychiatric services consist mainly of medication management and monitoring provided by a psychiatrist and psychiatric nurse. Out-patient services include diagnostic assessments, chemical dependency assessments and psychotherapy provided by therapists with Master's Degrees. Supportive outreach services include: in-home supportive counseling, assistance with daily living skills, social networking and transportation for program functions provided by a paraprofessional under supervision.

Estimating Need for Mental Health Services

Estimating the need for mental health services among elderly who live in

the community can be done utilizing primary or secondary data sources or both. Having more than one source is preferable in efforts to better substantiate the level of need. This research study used service statistics (primary data source) from the medical records of ZVMHC-RW to analyze the expressed need for community mental health services in Goodhue County. In other words, this approach provided the primary researcher a true barometer of what the elderly in this county are demanding of ZMVHC-RW in regard to mental health service. The second research question is designed to assist in the assessment of need using an alternate type or definition of need, "normative need" in comparison to "expressed need", concepts of social need by Bradshaw (as cited in York 1982 p.57). As described by Bradshaw, normative need is defined by experts or professionals to assist in problem identification. Expressed need is determined by how many people request a service.

Knowing the prevalence of mental illness within the target population, based on normative need, will provide a quantifiable assessment of need for mental health services among the elderly in Goodhue county. Comparing the estimated normative need to the expressed need will also provide a perspective of the unmet need.

This question will be addressed by taking prevalence rates of mental illness among the target population of elderly as provided in the literature reviewed. The rates were applied to the elderly population of Goodhue county based on 1990 Census Bureau data (secondary data source). These findings were then compared to the number of clients who utilized services at ZVMHC-RW. The results provide one perspective on the level of need for mental health services among the elderly population of Goodhue county and will be useful in the program planning process.

Chapter IV Research Findings

Overview

Research findings from the medical records review of 62 elderly clients, utilizing mental health services, are presented and summarized. Data is provided on the age distribution of the sample, socio-demographic and psychiatric characteristics and variables associated with accessibility to services. Projections of population growth and mental health needs for persons 65 and older in Goodhue county are made.

Research Findings

The Management Information System (MIS) produced a list of 77 individuals who met the criterion of being age 60 or older effective 10-1-94 and received mental health services between the dates 10/1/94 to 9/30/95 at Zumbro Valley Mental Health Center-Red Wing Unit (ZVMHC-RW). However, 15 of the 77 cases were excluded from the study. Thirteen cases did not meet the criteria of community-dwelling individuals (see p.3 for terms and definitions), 11 resided in nursing homes and 2 resided in group homes. Two cases were for information and referral services only and no medical record was opened. As a result, a total of 62 cases met the established eligibility criteria and were used as the study sample.

Calculations were made to determine the mean percentage of elderly who utilized mental health services from ZVMHC-RW during the defined one year period. Results indicate that 8% of all individuals who utilized services were age 60 and older.

The first variable presented is the age distribution of the study sample (see Table 3). The ages in this sample ranged from age 60-94. Over half the population (52%) are in the 60-70 age group. The highest percentages of individuals beyond age 70 are at ages 75 and 78. The lowest frequency of people are those age 80 and older, comprising about 16% of the total sample.

Table 3. Cumulative Percentage Age Distribution of Study Sample

Age	Absolute Frequency	Cumulative Frequency	Absolute Percent	Cumulative Percent
60	5	5	8	8
61	5	10	8	16
63	2	12	3	19
64	3	15	5	24
65	5	20	8	32
66	6	26	9	41
67	2	28	3	44
68	2	30	3	47
70	3	33	5	52
71	1	34	2	54
72	3	37	5	59
74	2	39	3	62
75	4	43	6	68
76	3	46	5	73
77	3	49	5	78
78	4	53	6	84
81	1	54	2	86
83	2	56	3	89
84	1	57	2	91
85	1	58	2	93
86	1	59	2	95
88	2	61	3	98
94	1	62	2	100

The measures of central tendency for this distribution were as follows: Mode = 66 Median = 70 Mean =71 Range =35

Table 4. 1995 Socio-demographic Characteristics by Three Age Groups (n=62)

Age	60-69	70-79	80+	Total
Study Population:	n=30	n=23	n=9	n=62
	# (%)	# (%)	# (%)	# (%)
Gender:				
Females	19 (63)	13 (57)	9 (100)	41(66)
Males	11 (37)	10 (43)	---	21(34)
Marital Status:				
Married	14 (47)	9 (39)	3 (33)	26(42)
Single	5 (17)	3 (3)	---	8 (13)
Divorced	3 (10)	2 (9)	1 (11)	6 (10)
Widowed	8 (26)	9 (39)	5 (56)	22(35)
Ethnic Background:				
White	30 (100)	23 (100)	9 (100)	62(100)
Household Composition:				
Lives Alone	12 (4)	12 (52)	3 (33)	28(45)
With Spouse	13 (43)	10 (44)	3 (33)	26(42)
Family Member	2 (7)	---	2 (23)	4 (6)
Non-family	3 (10)	1 (4)	1 (11)	5 (7)
Living Site:				
Private Residence	20 (67)	14 (61)	7 (78)	41(66)
Apt. (Not Age Specific)	7 (23)	3 (13)	1 (11)	11(18)
Apt. (Elderly Units Only)	---	5 (22)	---	5 (8)
Supportive Care Home	3 (10)	1 (4)	1 (11)	5 (8)

Listed below are observations made on the socio-demograghic characteristics presented in table 4.

Gender: Consistent with other studies, a higher percentage of service recipients are females (66%), especially as age increases. In this study,100% of persons age 80 and older were females. The percentage of females was higher in all three age groupings.

Marital Status: The percentage of those currently married decreases slightly as age increases. The percentage of those currently widowed increases significantly as age increases. The percentage of those widowed more than doubles between the 60-69 age group (26%) to those age 80 and older (56%).

Ethnic Background: There was no racial or ethnic diversity; all individuals in the study sample were Caucasian.

Living Site: A majority live in their own home (66%) v.s. living in rental units or in supportive living facilities. The same percentage lived in supportive living facilities (8%) as did those who lived in elderly housing units.

Household Composition: Nearly an equal proportion in each age group live alone compared to those living with a spouse. A relatively high percentage of those age 80 and older live with a family member other than a spouse.

A summary of psychiatric characteristics from the study are presented in Table 5. The category of mood disorders was the most prevalent group of diagnoses, it accounted for 35 of the 62 cases (56%). Major depression was the most prevalent individual diagnosis, found in 25 or (40%) of the 62 cases reviewed. In the age group of 80 and older all 9 cases were diagnosed with Major Depression. Psychotic disorders were diagnosed in 9 or (14%) of the 62 cases. An equal number of cases (4) had the diagnosis of schizophrenia and schizoaffective disorder. One of the 4 cases of schizophrenia was diagnosed as late onset schizophrenia. There were no individuals diagnosed with any type of cognitive disorder.

Table 5. Psychiatric Characteristics by Three Different Age Groups (n=62)

Age	60-69	70-79	80+	Total (%)
Mood Disorders:	11	15	9	35(56)
Major Depression	8	8	9	25(40)
Bipolar	3	4	---	7(11)
Depressive Disk.NO	---	3	---	3 (5)
Psychotic Disorders:	6	3	0	9(14)
Schizophrenia	2	2	---	4 (6)
Schizoaffective	3	1	---	4 (6)
Delusional	1	---	---	1 (2)
Cognitive Disorders:	0	0	0	----
Chemical Dependency:	7	1	---	8(13)
Anxiety Disorders:	1	3	---	4 (7)
Other diagnoses:	5	1	---	6(10)
TOTAL =	30	23	9	62

Variables associated with accessibility to services at ZVMHC-RW were examined. These included transportation, referral sources and case management services. In the area of transportation, an observation was made as to whether the individuals were able to drive to ZVMHC-RW or whether they were unable to drive and had to rely on someone else for transportation. As indicated in Table 6 below, slightly more people (52%, n= 32) required to be transported to the Center than those that drove themselves (48%, n= 30).

Table 6. Variables Associated with Accessibility to Services

Transportation n=62	percent	frequency
Drives	30	48
Does not	32	52
Referral Sources: n=54		
County Case Manager	30	56
Family, Friend, Neighbor	6	10
Community Professional	9	17
Self	9	17
Case Management: n=55		
Yes	34	62
No	21	38

The highest percentage of referrals to ZVMHC-RW were made by county social service case managers (56%). An equal number of referrals 9 (17%) were self- referred as made by other community professionals. Note that insufficient data prevented a determination of the referral source in 8 cases, therefore the percentages represent 54 cases and not the total 62 cases.

In 55 of the 62 cases sufficient data existed to determine whether or not the individual was receiving case management services at the time of referral to ZVMHC-RW. Findings indicate over three-fifths (62%) of individuals were receiving case management services.

The variable of social support network was operationalized by examining who if anyone the individual received social support from. This assessment was made by the therapist and does not necessarily represent the perceptions of the client. Findings presented in table 7 indicate that social support was

services through another clinic. Medical treatment was being provided in 33% of the cases simultaneously with mental health services. In-home health services were the most frequent formal service reported in conjunction with mental health services. A total of 25 of the 46 cases or 54% reported receiving in-home health services.

Projection of Need for Mental Health Services

Numerous journal articles on the subject of geriatric mental health cite estimates on the 65+ population that have significant mental health problems serious enough to warrant professional intervention (Blixen, 1988; Colenda & Dooren, 1993; Rosen & Rosen, 1982; Waxman "et al.", 1984). These estimates vary in a range from 10%-30%.

Table 8 shows the results of applying these estimates to the 65+ population of Goodhue county. Based on 1990 population data, results indicate, between 610 and 1,831 individuals in the 65+ age group are estimated to be in need of mental health services. It is difficult to know how many are actually receiving mental health services, but based on the total number of identified research subjects for this study, we do know that only a small proportion of those estimated in need, are receiving services through the local community mental health center (i.e., ZVMHC-RW).

Population Projections for Ages 65+ in Goodhue County

Table 9 shows the projected increase in the population of those 65 and older for Goodhue county by ten year intervals until the year 2020. Results indicate, by 2020 this age group is projected to increase by 45%.

Table 8. Projected Number of People Aged 65+ Who Are in Need of Mental Health Services

Estimated Prevalence Rates	Estimated # of Elderly Needing Mental Health Services	
Goodhue Co.	1990	2020
10%	610	883
20%	1,220	1,766
30%	1,831	2,649

Waxman, Carner & Klein (1984) estimated prevalence rates

Table 9. Projected Increase in Percentage and Number of People 65+ for Goodhue County.

Year	Number	Percentage Increase
1990	6,104	____
2000	6,620	8.4%
2010	7,010	15%
2020	8,830	45%

Projections were made by the Minnesota State Demographer's Office based on 1990 census data.

Chapter V Discussion

Overview

Results of this research are discussed in relation to other studies conducted that have focused on characteristics of the elderly and rates of service utilization. Similarities and differences in the findings compared to other studies are noted.

Discussion

The research findings of this study coincide closely with the study by Light et. al. (1986) who surveyed other Community Mental Health Centers and found CHMHCs with partially specialized centers had a service utilization rate of (M=8.8%) of persons 60+. In comparison, results from this study indicate ZVMHC-RW had a service utilization rate of (M= 8.0%). ZVMHC-RW met the operational definition established by Light and associates of a partially specialized CMHC because the Supportive Outreach Program has a specialized service but does not employ staff with specialty training in geriatric mental health. Services are designed to prevent nursing home placement and all individuals served are elderly. Other characteristics of the Supportive Outreach Program closely resemble those discussed in the study, including a variety of locations in which services are provided and transportation services.

The demographic characteristics of individuals in this research study are similar to those found in other studies. Similarities include a much higher proportion of females to males. A higher proportion of widowed females (with high rates of depression). Rates of divorce near 10% and a majority living in

their own homes with a large percentage receiving informal support from family members. One difference in demographics was the 100% Caucasian ethnic group. Other studies in the literature show that a majority of service recipients are white, but some ethnic diversity exists. Regarding psychiatric characteristics, a large proportion of individuals were diagnosed with mood disorders. This finding is consistent with other studies in the literature indicating that depression is the most common of emotional illnesses found in the elderly (Butler,1982; Waxman, et al. 1982). The fact that there were no individuals diagnosed with a cognitive disorder is a significant finding that is not consistent with other studies presented in the literature. Individuals with this diagnosis that were seen at ZVMHC-RW were residing in nursing homes and excluded from the study. A total of 9 cases were excluded, all with a diagnosis of dementia. This finding might indicate community dwelling individuals with this diagnosis are receiving services in other agencies or the problem is being undetected or under diagnosed.

Comparing the projected level of need in Goodhue county for mental health services to the actual number of persons aged 60 and older utilizing services at ZVMHC-RW, indicates there is a strong possibility that many individuals who need mental health services are not receiving them or are receiving them elsewhere. However, there is no data to support either position.

Chapter VI Limitations

This study has limited external validity. Since the data was gathered from only one mental health center in a rural setting, results of this study are not generalizable. No assumption can be made that the results of this study are representative of other mental health agencies serving elderly individuals diagnosed with a mental illness.

A second limitation of this study is that the measure of service utilization chosen was not a comprehensive measure of this variable. The nominal level measurement which was recorded could not describe the frequency and intensity of service utilization by the research subjects. Interval and ratio level measurements describing frequency and amount of service is required to capture all dimensions of service utilization. This limitation restricts program evaluation in regards to efficiency and effectiveness.

A third limitation relates to interrater reliability. The study involves judgments made by different therapists with no certainty to the extent of agreement, or consistency between them when making diagnostic assessments. Data collected was not tested for interrater reliability, therefore no judgment can be made about the amount of random error in the diagnosis assigned to each research subject.

Chapter VII Implications and Recommendations

Overview

Based on the information gathered from this research, implications for program planning are presented. Several planning tasks are outlined with specific service methods and treatment strategies recommended.

Implications and Recommendations

The primary purpose of this research study has been to complete an analysis of the elderly population who utilize community mental health services at ZVMHC-RW. The rationale for this effort was to provide a basis upon which program planning can take place in an informed atmosphere and to assist in the design of responsive mental health services for this target population. With the results analyzed, one must begin to consider the implications for planning purposes in efforts to determine where to go from here in the provision of mental health services for the elderly at ZVMHC-RW and other community-based organizations. Following are some preliminary recommendations and potential service alternatives, based on the limited information gathered from the medical records reviewed. Additional information through input from the consumers of the service and from other key informants would be essential prior to making any final program or policy recommendation.

In review of the legislation concerning the programs presented (Community Mental Health Centers Act; Community Support Programs; Minnesota Comprehensive Adult Mental Health Act; The Omnibus Reconciliation Act) it is clear that our national and state legislators legitimize the need for mental health services for the elderly. Legislation has specified the

need for comprehensive community-based services to prevent ,when possible, the need for long term care in institutionalized settings such as state hospitals and nursing homes. Funds from legislation have been appropriated for mental health programs and therefore influence the policies of programs implementing these services. In efforts to secure the continuation of public funds, service providers must keep informed of the legislative policies and understand their ramifications in regards to rules, regulations, protocols and priorities. These issues will have a significant impact on the planning process and internal policies. The need for administration to manage and negotiate relations with political, economic, public and private representatives is of paramount importance in order for an organization to remain viable.

Based on the percentage comparison of the elderly population distribution between the United States, Minnesota, and Goodhue county it is obvious that this particular county has a significant proportion of elderly people. Furthermore, based on the projected level of need for mental health services in Goodhue county, a closer examination of the strategies required to address the needs of this target population, by this organization and other community-based service providers is warranted. County projections indicate the number and proportion of elderly will continue to increase for the next forty years. Such a long term social condition would seem to warrant a long range commitment in the allocation of agency resources to this target population. The prevalence of psychiatric disorders in this population is well documented and projections for some disorders are expected to increase. It is projected by the year 2000,1 out of 3 people age 80 will have significant cognitive impairment resulting in dementia (Manhiemer, 1994). Service needs are likely to increase as the aging of our population continues.

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Appendix A

Service Recipient Data Sheet (SRDS)

Medical Record # _____ Recorder's Initials _____

Demographic characteristics

Program Type:
_____ Psychiatric services
_____ Out- Patient psychotherapy
_____ Community Support Services

Birthdate:
_____ Age

Gender:
_____ Male
_____ Female

Marital Status:
_____ Single
_____ Separated/divorced
_____ Married
_____ Widowed

Ethnic Background:
_____ White
_____ Hispanic
_____ American Indian
_____ African -American
_____ Asian
_____ Other

Living Site:
_____ Private residence
_____ Apartment complex (not age specific)
_____ Elderly housing units
_____ Supportive care residence
_____ Other (specify)

Household Composition:
_____ Lives alone
_____ With spouse
_____ Family member
_____ Non-family
_____ Insufficient data

Social Network:
_____ Family plus other support
_____ Family support only
_____ Other (nonfamily) support only
_____ None/none noted

Z V
Zumbro Valley Mental Health Center

Administration
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November 13, 1995

Rita Weisbrod, Ph.D., Chair
Augsburg College Institutional Review Board
2211 Riverside Avenue
Campus Mail # 186
Minneapolis, MN. 55454-1351

RE: Research Approval

Dear Ms. Weisbrod:

I am writing to you on behalf of Tim Mahoney, MSW graduate student at Augsburg College. Tim is a full time employee in our organization as Program Coordinator of the Community Support Program. Tim is also completing his field placement at the Red Wing Unit of Zumbro Valley Mental Health Center. He will be conducting a research study at our Red Wing Unit titled, Descriptive Analysis of Elderly People Utilizing Mental Health Services. We believe this research will be a valuable contribution to future planning in our organization. We give Tim our enthusiastic support and appreciate his efforts on this project.

Tim has our permission to use medical records of patients chosen for the study. Tim is aware of our policies and procedures regarding the use of client records and has been practicing them appropriately during the past seven years of employment with us.

If I can be of any further assistance regarding this matter feel free to contact me at (612) 388-0451.

Sincerely,

Bob Glasenapp

Bob Glasenapp, MPA
Unit Director

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(507) 281-6223

POLICY ON DATA PRIVACY AND YOUR RIGHTS

Data is collected by this agency for the purpose of providing services to you, including evaluation and therapy. As part of this data collection, this agency creates a medical record about each client. Medical records may be used by the following agency staff: clinical staff, supervisors, receptionists, word processors and personnel from medical records and the billing office. Information from your medical record can be reviewed by your insurance company if you give your written consent.

You have the right to refuse to give any information at any time. Refusing to supply information may result in recommendations being made based on incomplete information or may affect our ability to provide competent evaluation and therapy. If you are eligible to receive county funding, some information about you will be provided to county social services staff. The Minnesota Department of Human Services also has the right to review your medical record.

We occasionally develop statistics and other anonymous information about the clients we serve that will not identify you in any way.

Private information may be released to any person or organization you choose, if you have given us your informed consent in writing. There are situations when we may share information without your consent. These are listed in the brochure you received on "Client Rights and Responsibilities" under the section about "Privacy and Confidentiality." A release of information is not needed to share information about you with other programs of Zumbro Valley Mental Health Center. If you have questions about limits of confidentiality, please speak to your therapist.

MISSED APPOINTMENT POLICY

When you make an appointment with our office, time is set aside for you. If you are unable to keep an appointment, please contact our office 24 hours in advance.

In order to provide responsive and affordable services to all of our clients, we must charge for missed appointments. It is our policy to charge $20.00 per hour for appointments not cancelled 24 hours in advance.

We cannot bill your insurance company, Medical Assistance, Medicare or the sliding fee scale for missed appointments. Any charge for missed appointments will be made directly to you. If you are charged a Missed Appointment Fee, we prefer that payment be made in person at our outpatient office.

I have read and understand the above policies.

_____ _____

Client Signature Date