

Broome County Mental Health Department



Mental Health Needs Assessment of Broome County's Elderly Population

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LITERATURE REVIEW

In order to assess the mental health status and needs of elderly individuals beyond Broome County, a literature review was conducted. Findings from this review are presented with the intention of broadening the reader's understanding of mental health issues affecting this population.

Prevalence of Mental Disorders among the Elderly

Although elderly individuals account for a large percentage of Broome County's population (16.37% are over the age of 65, compared to 12.9% of New York State's population; Census, 2000), many of their needs go unsatisfied.

Prevalence rates for mental disorders among the elderly range from 12.3% of those over the age of 65 (Regier et al., 1988) to 19.8% of those over the age of 55 (U.S. Department of Health and Human Services, 1999). The Surgeon General's report on mental health also provides the results of a national prevalence survey. The national prevalence of psychological disorders in those aged 55 and over is as follows: anxiety disorders, 11.4%, mood disorders, 4.4%, schizophrenia, 0.6%, somatization disorders, 0.3%, and severe cognitive impairment, 6.6%. However, these rates could reflect an underrepresentation of the actual prevalence. For instance, it is thought that physicians are less likely to recognize psychological symptoms in older adults than younger (Rapp, Parisi, Walsh, & Wallace, 1988), and studies show that 44% of mental health services are conducted through the general health sector (Burns & Taube, 1990).

The Epidemiological Catchment Study (Regier et al., 1988) reported that the lowest prevalence among age groups for substance use disorders, alcohol abuse/dependence, and drug abuse/dependence was found among those over the age of 65 (all under 1%). However, these percentages most likely reflect an underreporting of the disorders due to their secretive nature and the types of drugs abused, particularly prescription and over-the-counter medications (Miller, Belkin, & Gold, 1991). These drugs can be easily misused without intent because of cognitive problems (Baum, Kennedy, & Forbes, 1985) and because of misunderstanding the instructions for taking medications. In addition, reactions to drugs often change as the individual ages, and if not noticed by a primary physician, the individual may continue taking a drug that no longer has the same beneficial effect. Consequences of drug use are also different in the elderly from younger populations: because their dependence is often not evident through lapses in responsibilities, drug dependence is often seen mainly through ensuing psychiatric and medical problems (Miller, Belkin, & Gold, 1991).

Of all age groups, those over the age of 65 have the highest rates of suicide (Turvey et al., 2002). Turvey and colleagues' (2002) study of completed suicides from the Established Populations for Epidemiologic Studies of the Elderly (EPESSE) found that suicides were correlated with having more depressive symptoms, poorer sleep, perceived poorer health, and less social support than individuals who had not attempted suicide. Suicide did not correlate with alcohol use, chronic illness, or physical or cognitive impairment. The study also found a number of variables that were negatively correlated with suicide, namely the presence of friends and relatives and regular attendance at church, suggesting that non-suicidal individuals were able to establish and maintain

connections to the larger community (Turvey et al., 2002). However, because the sample of completed suicides consisted mostly of males, it is conceivable that these findings apply mainly to elderly males (Turvey et al., 2002).

Elderly in Rural Communities

Individuals over the age of 65 living in rural areas present a challenge to the mental health community. Studies estimate that 15-20% of these individuals have a psychiatric illness (Dowart, 1990; Rathbone-McCuan, 1993). Neese and colleagues (1999) stated that 29% of their sample of rural elderly reported experiencing a mood disorder. However, barriers to the utilization of mental health services do exist; these include the availability of mental health services in the community, the accessibility of the services, and the acceptability of discussing and receiving services for mental health issues (Fox, Merwin, & Blank, 1995). Rural elderly were more likely to seek services for mental health issues if they were married and had other insurance in addition to Medicare (Neese, Abraham, & Buckwalter, 1999).

Placement of Elderly with Mental Disorders

A number of elderly individuals are eventually placed at a nursing home; several factors have been found to be consistent with this placement. These factors include advancing age, living alone, and mental health status (Branch & Jette, 1982). Black, Rabins, and German's study (1999) on risk factors for nursing home placement among elderly public housing residents found that functional level and mental status greatly predicted nursing home placement. The principle goal of the federal Omnibus Budget

Reconciliation Act of 1987 (Public Law 100-203) is to limit the use of nursing homes for long-term mental health care (Bartels, Levine, & Shea, 1999). The law requires that those presenting only with mental disorders seek treatment in a facility other than a nursing home (Gatz & Smyer, 1992). However, studies show that approximately 89% of those institutionalized with serious and persistent mental illnesses reside in nursing homes (Burns, 1991). Nursing home placement increased as the need for assistance in daily activities, cognitive disorder, symptoms of emotional distress, and psychotic symptoms increased (Black, Rabins, & German, 1999).

Despite deinstitutionalization, the psychological care of the elderly in state hospitals is still relatively common (Moak & Fisher, 1991). Rather than outpatient services replacing inpatient, both types of services are increasing (Gatz & Smyer, 1992). In addition, it is no longer the case that the majority of inpatient services can be found in state hospitals; many inpatient services are run out of private psychiatric hospitals and psychiatric units at general hospitals (Gatz & Smyer, 1992). However, many hospitals are ill equipped to deal with this population. Less than 10% of hospitals surveyed specialized in geriatric care, while 43% of hospitals reported having no clinicians with specific training in geriatrics (Moak & Fisher, 1991).

Mental Health Services for Elderly

Literature reports a lack of services available to elderly individuals with severe and persistent mental illness (Bartels, Levine, & Shea, 1999). Approximately 2% of those aged 55 and over are seriously and persistently mentally ill (Goldman & Manderscheid, 1987); this number is expected to double before 2030 (Cohen, 1995).

This category includes individuals with diagnoses such as schizophrenia, delusional disorders, and affective disorders like bipolar disorder and major depression (George, 1992). These individuals often experience functional difficulties and cognitive impairment, as well as medical problems (Bartels, Mueser, & Miles, 1997a; Bartels, Mueser, & Miles, 1997b). Although they require a wide range of services (Bartels, Levine, & Shea, 1999), many individuals in the community receive little more mental health assistance than medication (Meeks & Murrell, 1997).

In their survey of middle aged and elderly individuals diagnosed with a psychotic disorder (schizophrenia, schizoaffective disorder, or a mood disorder), Auslander and Jeste (2002) found that when asked to rate various needs related to improving their quality of life, participants gave highest priority to improving areas of social functioning, learning about their own mental illness, and improving their sleep and mood. They gave lowest priority to drug and alcohol rehabilitation and reducing psychiatric hospitalizations. This may reflect the finding that the frequency of psychiatric hospitalizations for schizophrenia decreases as the patients grow older (Auslander & Jeste, 2002; Cohen, 1990).

Proctor and colleagues (1999) followed 60 elderly individuals who were released from a psychiatric unit into a community setting to track their use of services within a one month time period. Of these individuals, 76% had a diagnosis of an affective disorder, 8% had a psychotic disorder, and 8% had dementia. In general, service utilization was low, with a minority of those surveyed using a majority of the services; the mean number of services used within the month was 4.2 and the majority of individuals utilized services twice. Services were sought for assistance with a mental disorder (44% of the

episodes), for general health reasons (32%), and for assistance with functional impairment (23%). Most of the services came from the mental health sector (38% of services), the general health sector (35%), and from social and aging services (27%). However, after release from a psychiatric inpatient unit, a period of intense service use should follow. The current study questions if individuals receive enough services after release (Proctor, Morrow-Howell, Rubin, & Ringenberg, 1999).

Community Based Solutions

Community based mental health care is an alternative to state hospitals and nursing homes that offers several benefits to both clients and the community. Besides fulfilling many elderly individuals' requests to remain in their own homes, community programs increase participation by family members and help to improve the client's quality of life (Bernstein & Hensley, 1993). Community programs provide a referral network (Shaw et al., 2000), and the emphasis on social support and physical functioning is ideal for individuals whose psychotic symptoms have stabilized or consist mainly of 'negative' symptoms such as flattened affect and anhedonia (Shaw et al., 2000). This emphasis on social support has been correlated with longevity in schizophrenics (Christensen, Dornink, Ehlers, & Schultz, 1999). In a study of community alternatives in Tampa, FL, researchers found that 91% of the elders involved in the programs could be maintained successfully in community programs including supportive case management, day treatment, mental health teams, mental health support to caregivers, and permanent housing situations that include supportive case management and day treatment (Bernstein & Hensley, 1993). In addition, community-based programs bring business into the

community and save taxpayer money (Bernstein & Hensley, 1993). Despite these advantages, community-based programs are not utilized as often as they could be. In their survey of state hospitals, Moak and Fisher (1991) found that while 45% of hospitals reported that there was a community mental health center with an elderly program in the area, 37% reported that this was not the case.

Purpose of the Present Study

The aim of the present study was to assess the existing programs offered by organizations in Broome County for elderly who are seriously and persistently mentally ill. This information would then be used to determine gaps in service and to make recommendations as to future services. While these goals are similar to those of the Aging Futures II Committee of Broome County, funded by a grant from the Robert Wood Johnson Foundation, the present study focuses exclusively on mental health issues in the elderly population.

METHODS

Demographic Data

To more extensively understand the mental health needs of the elderly in Broome County, demographic data were compiled from a number of sources. These sources included the Census 2000 data and the 1999 Patient Characteristics Survey from the New York State Office of Mental Health (The 2000 Patient Characteristics Survey was not available at the time this report was written.). This information will be reported in the Results section, relevant graphs can be found in Appendix A.

Surveys

Surveys were compiled to assess basic descriptive information about services offered through various organizations, as well as the consumers of those services. The surveys were piloted at two sites that would later participate in the final interviews; contributions were incorporated into the final versions of the surveys. Three surveys were created: one assessing community based mental health programs, another assessing living facilities such as nursing homes and family care homes, and the last assessing inpatient mental health facilities (See Appendix B.). Each survey inquired about programs offered to the elderly population, the percentage of clients aged 65 and over, and the portion of those clients that could be considered seriously and persistently mentally ill (SPMI). Organizations were provided with a basic definition of SPMIs with which to make their classifications—individuals with chronic mental illness who have an extended impairment in functioning due to the mental illness or are at a high risk for

repeated psychiatric hospitalizations. The different surveys also asked questions specific to that type of facility, such as discharge plans, referral sources, and mortality rates. Surveys were conducted either on-site or over the telephone. Answers to the specific survey questions were collected, but interviewees were also asked to share any additional information they felt was pertinent, as well as their concerns for or obstacles they perceive in the treatment of the elderly population.

Consumer Surveys

In order to ascertain the opinions of elderly consumers of mental health services, a consumer survey was created with the help of Broome County's Recipient Affairs Office. This 13-question survey was given to individuals above the age of 65. Participants in the survey were volunteers from two locations: residents of Renaissance plaza over the age of 65 were asked if they would participate. In addition, surveys with self-addressed stamped envelopes were mailed to elderly clients of the Broome County Mental Health Clinic. All participants were informed that the information was being collected for research purposes and that the surveys were completely anonymous and voluntary. Five individuals from Renaissance Plaza participated, although all but one were excluded because they did not meet the age criteria. Forty-five surveys were mailed to clients of the Broome County Mental Health Clinic; rate of return was 38%.

CPEP Data

Although United Health Services Hospital's Comprehensive Psychiatric Emergency Program (CPEP) was contacted to participate in the study, they do not

differentiate between the adult and geriatric populations in their data collection. Therefore, CPEP data was not reviewed for this needs assessment.

Agency Participants

Sixteen organizations offering mental health services to individuals over the age of 65, although not necessarily offering services exclusively to these individuals, were surveyed. They were first sent a letter of introduction to the project, as well as copies of the surveys that applied best to their services. A follow up call was made to arrange an in-person or telephone interview. Of the 16 organizations initially contacted, 9 interviews were conducted in person, 3 were conducted over the telephone, 1 was conducted by an individual other than the principle interviewer, and 3 organizations did not respond to the survey request. Nine organizations completed the community-based survey, 3 completed the living facilities survey, and 2 completed the inpatient facilities survey.

RESULTS

Demographic Data

According to the 2000 Census, individuals over the age of 65 comprise 16.37% of Broome County's total population, compared with 12.9% of New York State's total population (U.S. Census Bureau, 2000; see Appendix A, Figure 1.).

The Patient Characteristics Survey reports demographics of those individuals seeking mental health services in Broome County within a one-week period. During this one-week period in 1999, of individuals over the age of 65, 17 utilized emergency services, 50 were involved in inpatient services, 41 took part in outpatient services, 40 were enrolled in a mental health residential program, and 19 were involved in a community non-residential program (Office of Mental Health, 1999; See Appendix A, Figure 2.). It must be noted that these figures may represent duplicated cases. Sixty-one percent of those receiving services were female (OMH, 1999), 95% were white non-Hispanic and 4% were black non-Hispanic (OMH, 1999).

Action for Older Persons' *Broome County Elder Services Guide*

Action for Older Persons compiles and distributes, with assistance from Office for Aging and United Way's First Call for Help, the Broome County Elder Services Guide, a comprehensive directory of services available to the elderly population. Of the 266 agencies listed in the 1999-2000 edition of the guide, 25 fell within the realm of counseling/mental health. However, these included several agencies that were fairly specific in scope (i.e., the Kidney Foundation of Northeast New York) or that provided

referrals or information (i.e., the Mental Health Association), rather than general mental health services. The agencies listed under Counseling/Mental Health in the Elder Services Guide are reproduced in Appendix C, while a list of elderly mental health services compiled by the author can be found in Appendix D. Although the author's list represents many of the programs available to and specifically for the elderly, it is not meant to be all-inclusive.

Agency Survey

Limitations

Prior to reading the results of this survey, several limitations must be noted. First, the facilities contacted for this survey represent only a portion of the services available in Broome County. These facilities are intended to reflect a representative sample; they are in no way intended to be all-inclusive.

Second, not all facilities used the age of 65 to designate the cutoff for the elderly population. Some programs quoted an age of 62, others 60. Data that are reported here reflect the particular age cutoff used by a facility. Therefore, not all information reflects the population aged 65 and over; however, the report does reflect the population considered by the facility to be elderly.

Third, facilities were asked to provide exact numbers whenever possible. However, when exact numbers were not available, an estimate was accepted. The data reported here represents a combination of exact numbers collected by the facility and an estimate of the true number reported by the individual being interviewed.

Fourth, facilities were asked to report data over a twelve-month period. However, for some facilities, this was not possible. Therefore, responses were modified so that they reflect a uniform twelve-month period. For the reasons listed above, the results of this study must be interpreted with caution.

Inpatient Psychiatric Facilities

BINGHAMTON PSYCHIATRIC CENTER, UNITED HEALTH SERVICES

There are two inpatient psychiatric facilities located in Broome County. The first is run by United Health Services Hospitals (UHS), and the second is state-run Binghamton Psychiatric Center (BPC). UHS does not compile the same data as BPC; therefore, some comparisons between UHS and BPC could not be drawn.

The average length of stay for a patient at BPC is 60 days. Of the 154 beds in BPC, 31 of these are located in their geriatric unit, and of the 300 patients who were treated over the past twelve months, 15% were geriatric. All geriatric individuals in BPC are seriously and persistently mentally ill.

The elderly at BPC utilize many programs that were not designed specifically for that population; programs include religious services, patient events and activities, and medical and dental programs. However, BPC does have programs specifically designed for their geriatric population. These include a Geriatric Treatment Mall, which features groups and events specifically for those 65 and over, and a geriatric psychiatry fellowship program. Through the geriatric fellowship program, which operates in conjunction with Columbia Presbyterian Hospital, BPC currently has four geriatric psychiatry fellows in residence.

Over the past twelve months, BPC saw 20 discharges and 1 natural death among their geriatric population. Ten individuals were discharged to a nursing home, and ten were discharged to BPC's outpatient services, such as the community preparation program and family care, or to their own families.

Of the 1,690 individuals admitted to UHS's inpatient psychiatric unit in 2002, 15% of these were over the age of 65. The average length of stay in UHS's inpatient psychiatric unit regardless of age is 11.5 days, with times ranging from one day to 60. Elderly individuals reside mainly on Krems 5; however, this ward is not solely for the elderly. There are no programs available specifically for geriatric patients, but they have access to any of the programs available. Although data on the number of elderly individuals considered SPMI were not available, the most common mental health issues are depression, chronic psychiatric problems, and dementia. In 2002, 250 geriatric individuals were discharged from UHS's inpatient psychiatric unit—130 were discharged to their homes, 68 were discharged to a nursing home, and 40 went to a residential support program. The remainder of the individuals was discharged to an agency specializing in medical care, or their discharge plans were not recorded. UHS's inpatient psychiatric unit saw 1 natural death.

Living Facilities

RENAISSANCE PLAZA, WILLOW POINT NURSING HOME, CATHOLIC CHARITIES' RESIDENTIAL MENTAL HEALTH PROGRAMS, BPC'S FAMILY CARE PROGRAM

Several residential programs were surveyed. While the number of mental health programs at each facility varied (Renaissance Plaza has three mental health programs, Catholic Charities has five mental health programs, and Willow Point Nursing Home's

mental health program consists of ten medical social workers.), none of the facilities had mental health programs specific to the elderly. Although the Catholic Charities Residential Mental Health Programs, Willow Point Nursing Home, and Renaissance Plaza all had over 300 residents over a twelve-month period, the percentage of elderly individuals served at each facility varied greatly. Of the 74 people in BPC’s Family Care Program, 39% are aged 65 and over. (See Table 1.)

Table 1: Percentage over age 65 at each facility

Facility	Percentage 65+
Catholic Charities	0.3%
Willow Point Nursing Home	93%
Renaissance Plaza	70%
Family Care Program	39%

The mental health status of residents in BPC’s Family Care Program is continuously evaluated, and residents must comply with this evaluation. Renaissance Plaza reported that 15-20% of their residents over the age of 65 participated in mental health programs. According to a representative at Willow Point Nursing Home, which does not have any specific mental health programs, residents would benefit from the addition of such a program.

The number of elderly individuals in each program with a severe and persistent mental illness also differed. A mental illness of this type is necessary for admission into Catholic Charities’ residential program, and 100% of their clients meet such criteria. This also applies to BPC’s Family Care Program. At Renaissance Plaza, 25% of residents could be categorized as seriously and persistently mentally ill. This was also true for 9% of residents at Willow Point Nursing Home (See Table 2.).

Table 2: Percentage of those over age 65 considered seriously and persistently mentally ill at each facility

Facility	Percentage 65+ SPMI
Catholic Charities	100%
Willow Point Nursing Home	9%
Renaissance Plaza	25%
Family Care Program	98%

The number of referrals to an inpatient psychiatric unit was similar. Representatives at Willow Point Nursing Home reported 10 referrals a year, while 12 referrals a year were reported by Renaissance Plaza; the data from Catholic Charities' residential program was not available. However, this was significantly smaller in BPC's Family Care Program, possibly because of their strong mental health component or the intensive case management (One individual was readmitted to the inpatient unit.).

The percentage of elderly individuals who were referred to the program from an inpatient psychiatric unit differed dramatically. While these individuals accounted for less than 1% of residents at Willow Point Nursing Home, they accounted for 42.5% of residents at Renaissance Plaza (The data was not available from Catholic Charities' residential program.). Four individuals were placed in a nursing home from the Family Care Program; this information was not available from or did not apply to the other facilities surveyed.

Community-Based Programs

Home Care

FAMILY AND CHILDREN'S SERVICES, LOURDES AT HOME, TWIN TIER HOME HEALTH, HOME, CASA

Services provided under home care involve counseling that is done in the home of the elderly individual. Family and Children's Services offer several programs for elderly individuals, three of which have a mental health component. They offer senior peer counseling for adjustment issues, elder counseling for more involved mental health needs, and in-home mental health management. The in-home mental health management program offers services and support—including assistance with medication—to the chronically mentally ill. No counseling services are included in the latter program, however.

Only individuals who have a medical problem can utilize programs offered by Lourdes at Home. To address mental health issues, they employ one medical social worker. Although treatment is not intensive, the social worker does refer individuals to more extensive treatment. The social work services are available to those recommended by visiting nurses, individuals who have a new medical diagnosis, or anyone requesting such services.

Similarly, Twin Tier Home Health Care emphasizes the clients' medical needs. To address mental health issues, medical social workers are available. However, counseling is done on a short-term basis (approximately four sessions) and as needed.

Broome County CASA offers elderly clients several programs, including the in-home mental health program. Offered in conjunction with Family and Children's

Services, this program specializes in teaching organizational skills to individuals who are not medication compliant (A prescription for a psychotropic medication is required to be admitted to the program.). The goal of the program is to help clients become more independent.

The Mental Health Outreach Program (Helping through Outreach and Mental Health for the Elderly; HOME) offered by UHS is the only program surveyed that exclusively offered mental health assistance to elderly individuals. Staffed by only three individuals, the HOME program offers mental health assessment, counseling, referrals, and the expertise of geriatric psychiatry fellows on an as needed basis in the individual’s home. The goal of the program is to avoid hospitalization.

Of the home care programs, all have at least one mental health program. All but UHS’s HOME program offer programs other than mental health. The majority of clients served in each program are elderly, with each program having 80% or more of their clients from the elderly population. The percentage of elderly individuals considered seriously and persistently mentally ill ranges from 1% in Twin Tier Home Health to 35% in the HOME program (See Table 3.).

Table 3: Data collected from community-based home care programs

Facility	Percentage 65+ SPMI	Referrals to CPEP/Inpatient Psych Unit	Referrals to Nursing Homes
CASA	18%	12	500
Family & Children’s	20%	5	5
HOME	35%	8	8
Lourdes at Home	10-15%	2-3	*
Twin Tier Home Health	1%	10-15	130

* Patients will eventually be referred to a nursing home if they do not die of natural causes.

The number of individuals referred to an inpatient psychiatric unit or to CPEP ranged from 2 to 3 a year (Lourdes at Home) to 10-15 a year (Twin Tier Home Health) (See Table 3.).

When asked how many individuals were placed in a nursing home in the past twelve months, responses varied greatly, from 5 (Family and Children's Services) to 500 (CASA). A representative from Lourdes at Home stated that in their long-term care program, individuals are either referred to a nursing home or die before they are referred (See Table 3.). However, each program stressed that these individuals are not referred to a nursing home for mental health reasons. They are simply unable to care for themselves, families are unable to care for them, or medical issues necessitate admission to a nursing home.

Outpatient

BROOME COUNTY MENTAL HEALTH DEPARTMENT'S ADULT CLINIC, UHS'S COMMUNITY PROGRAMS, BPC'S OUTPATIENT SERVICES

Programs offered by the different outpatient facilities surveyed varied substantially. Broome County Mental Health Department's Adult Clinic provides mental health services to people of all ages. The current number of adult clients seen in the clinic is 1,171. Of this number, approximately 7% were 65 years or older, and 73% of these individuals are seriously and persistently mentally ill. Approximately 1,190 treatment sessions were provided at the clinic to these elderly individuals in 2002. Although records are not kept on the number of placements into inpatient psychiatric units and nursing homes, a representative of the clinic felt that only a small percentage of elderly individuals involved in the program were placed into an inpatient psychiatric unit.

Community programs offered by United Health Services were not specific to the elderly population, although several groups that fit such a description are no longer running. Of an estimated 700 individuals served in twelve months, 5% were elderly, and only 10% of those elderly individuals were seriously and persistently mentally ill. Although exact data on placements in inpatient psychiatric units or nursing facilities were not available, the UHS representative did not believe that such placements occurred often, most likely because one of the goals of the outpatient unit is to stabilize the individual's social support network.

Binghamton Psychiatric Center has several mental health programs, two of which—Family Care and the Community Preparation Unit—were mentioned previously. However, as they are considered part of the outpatient unit, outpatient statistics reflect these programs. Programs offered by BPC include case management, an Intensive Psychiatric Rehabilitation and Treatment program (IPRT), a mobile trauma team, and a social club comprised mostly of geriatrics. Although these programs are not specifically for the elderly population, they are open to and utilized by them. Two programs are offered exclusively to the geriatric population. The Prepaid Mental Health Plan is offered to outpatients over the age of 18 who are Medicaid recipients and provides services in the areas of treatment, rehabilitation, support, crisis intervention, and self-help. Individuals design a personalized package to meet their goals. As part of this plan, BPC staff follows 27-30 individuals in nursing homes who had been released from BPC. Services consist mainly of consultations with a social worker and a geriatric psychiatry fellow. The geriatric mobile team provides evaluation, consultation, and the transfer of elderly individuals with psychiatric problems. Work is done off-site by a social worker and a

geriatric psychiatry fellow. The geriatric mobile team is utilized approximately 1-5 times a month, and less than 20% of individuals seen are committed to BPC.

A total of 420 individuals were treated in BPC outpatient programs over a twelve-month period. Of these, nearly 27% were 65 and over. In addition, 98% of those over the age of 65 are considered seriously and persistently mentally ill. Over a twelve-month period, 6 elderly individuals were placed at an inpatient psychiatric unit, and 5 were placed at a nursing facility.

Consumer Survey

Of the 15 individuals over the age of 65 ($M = 73.4$ years, $SD = 6.5$ years) participating in mental health programs who returned the survey, 12 were female. The majority of individuals (26.7%) reported a combination of counseling and psychiatrist visits as the mental health services currently being received. Nearly 27% reported receiving psychiatric services, which include a combination of counseling and medication management, while 7% reported receiving counseling services alone. Over 33% reported receiving a combination of counseling and psychiatric services. Only 2 individuals reported that they were receiving mental health services specifically for their age group, while 10 individuals reported that they were not. Five individuals stated that they would like to have services specifically for their age group, while five stated they would not. While the majority of individuals (80%) reported being satisfied with the care they were receiving, some individuals (13%) did list concerns with the mental health system, including distance to the clinic, medication cost, and low frequency of visits. When asked what could be done to make access to mental health services more convenient,

participants listed factors such as cost of services, accessibility of services, and transportation to services.

Stakeholders' Comments

During the interview, facility representatives were asked to comment on gaps in service that they perceive. Several individuals listed problems with medication as a major issue. These problems included the high cost of medications, having many medications prescribed to an individual, incorrect usage of the medication, infrequent monitoring of medication effectiveness, and a lack of doctor control over medication interaction.

Inadequate transportation and poor access to services frequently was listed as a problem. Several representatives felt that it is extremely difficult for elderly individuals to come in to a clinic for treatment; this is aggravated by the lack of services in rural areas around Broome County. Related to this is the perceived need for more mental health services in the community, including more case management and more organizations, like the HOME program, that deliver services at the individual's location.

Obstacles to providing services are numerous. Several organization representatives reported the observation that the stigma of a mental illness still exists in the elderly population. This stigma prevents individuals in need of assistance from seeking help. In addition, social isolation is a potential problem in the elderly population. Steps should be taken, such as installing social activities, to lessen the problem, and mental health workers should be sensitive to this factor.

The staff at the HOME program has identified 10% of their elderly population that acts as the sole provider for their children or grandchildren. These individuals fear the fate of those in their care should they die, be sent to a nursing home, or be deemed an inappropriate caregiver; provisions for the children other than foster care and institutionalization should be in place to address such a situation.

There is also a perceived lack of understanding towards the inseparable relationship between medical and psychological problems. Nurses in medical home care organizations are not qualified to provide counseling services to their clients, even though many are in need of such services, and the nurses see the individuals on a regular basis. Stakeholders also perceive a need for increased psychological care in nursing homes, including long-term treatment.

Some representatives were concerned about the lack of coordination across treatment providers. Elderly individuals often see a variety of doctors for a variety of ailments, and receive a variety of medications. The lack of a central system makes it difficult to determine the effects a possible treatment would have on other existing treatments, as well as making it more difficult to identify an individual's primary doctor. The need for greater interaction between programs was also identified.

CONCLUSIONS

Although elderly individuals comprise a significant portion of Broome County's population, their mental health needs are not fully met. Several organizations, such as the Office for Aging, do their best to refer individuals to the limited services available, while organizations like Action for Older Persons do their best to make the available resources known to consumers.

Living facilities were not universal in the level of mental health care they provided. With the exception of BPC's Family Care Program, mental health was not the focus of care at any of the living facilities. However, each facility surveyed housed a number of people considered seriously and persistently mentally ill. The severity of the patient's needs did not correspond with the number of mental health services offered to residents of the facility. In addition, while Renaissance Plaza and Willow Point Nursing home had a number of referrals to inpatient units in one year, BPC's Family Care Program had significantly less, although the program houses a greater percentage of seriously and persistently mentally ill individuals. This may be due to the higher levels of mental health care received by residents in this program.

Inpatient psychiatric units appeared well run and well organized. Of note is BPC, which has treatment areas specifically for geriatric patients and which has excellent interplay between the inpatient and outpatient units. Although BPC did refer elderly individuals to nursing homes, a number of these individuals were followed by BPC staff as part of the pre-paid mental health plan discussed earlier.

Based on the survey and comments of stakeholders, it can be concluded that the mental health needs of the elderly population are not being fully met. There is a greater need for community based programs than there are services. Although outpatient agencies do provide services to the elderly, none of the agencies surveyed provide services specifically for the elderly. In addition, because of various problems such as transportation issues, physical problems, and cost, many elderly individuals are unable to travel to the outpatient program to receive services. Most stakeholders were also quick to note that the problems with mental health services for the elderly extend beyond those individuals who are seriously and persistently mentally ill. The majority of elderly individuals, whether SPMI or not, have mental health needs, and these needs generally go unaccounted for. All gaps in service and recommendations in this paper can be applied to elderly individuals who are not seriously and persistently mentally ill.

Although comments from consumers were positive, it must be emphasized that these individuals are already receiving mental health services in the community. In addition, all but one individual surveyed are clients at the same outpatient mental health agency in Broome County. While reports from the survey participants suggest that existing services may be adequate for a portion of the population, it must be understood that these findings cannot be generalized to the elderly population as a whole, as different services are provided at different agencies. In addition, these individuals reflect the portion of the population that is able to come to an agency for treatment; transportation to and availability of services is an issue for many elderly adults.

A strong need exists for at-home services, such as UHS's HOME program, which appears severely understaffed, considering the demand for such resources. However,

many at-home services are specifically for medical conditions, and any counseling that may occur is short term, and those receiving such services must have a medical problem severe enough to warrant the at-home treatment. Besides being more cost effective than long-term and emergency treatment, allowing individuals to remain at home while receiving treatment improves the individual's quality of life (Bernstein & Hensley, 1993).

Several directions can be taken for the future allocation of resources. First, many stakeholders cite difficulties in providing mental health services due to a lack of transportation. This includes not being able to provide individuals in rural areas with assistance because of their distance from any mental health service. One option may be to provide shuttle service to and from counseling sessions. Another may be to supplement the funds of in-home mental service providers so that they can afford to travel the distances to elderly clients' homes. Yet another would be to set up programs in areas that cannot readily access existing programs because of distance.

Problems with medications are another frequently cited problem, including the high cost of medications, having many medications prescribed to an individual, incorrect usage of the medication, infrequent monitoring of medication effectiveness, and a lack of doctor control over medication interaction. These problems may be alleviated by the installation of a central computer system, from which one could access all medical and psychiatric records on a particular individual. This would also serve to reduce confusion as to medication interactions and treatments, as all information would be readily available.

Above all, however, there exists a need for more community-based mental health organizations, especially those providing in-home services. As stated in the introduction,

community-based mental health care proves beneficial to both the individual and the community in personal and economic ways, while providing services in the individual's home allows those who would not be able to travel to participate in the services. A review of the agencies in Broome County revealed that strikingly few agencies exist, and future resources should be allocated to founding and developing such organizations. It is the opinion of the author that one program in particular, the HOME program, should be seen as a prototype for such organizations, and this program should either be expanded upon or modeled after.

By focusing resources on developing community-based programs and making these and existing programs more accessible to those desiring services, including individuals who's mental health needs are not severe enough to earn them the label of seriously and persistently mentally ill, substantial gains can be made in providing mental health services to those elderly individuals in need of them.

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Appendix A

Demographic Data

**Figure 1:
Population, by Age**

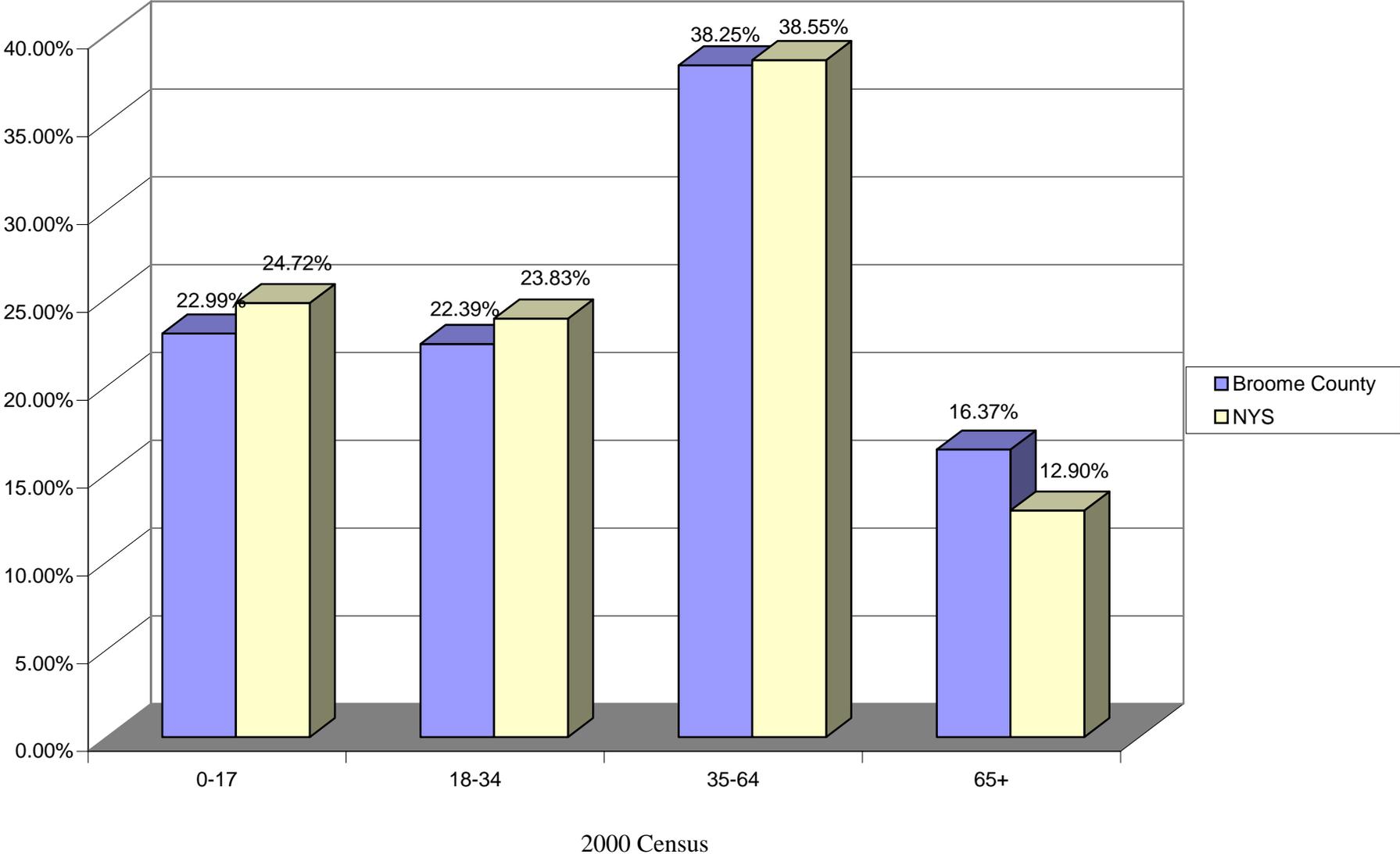
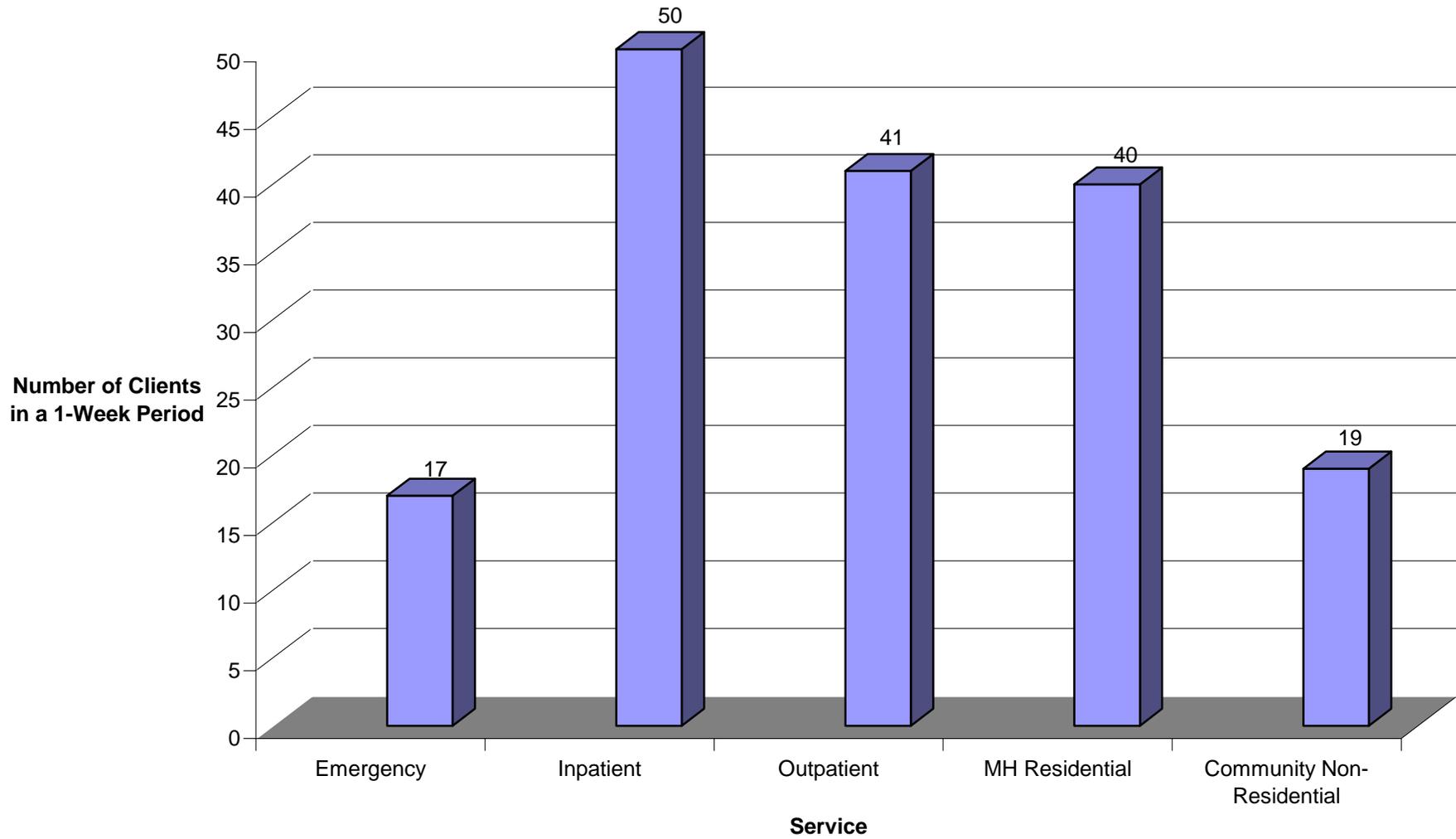


Figure 2:
Clients Age 65+ Served in Mental Health Programs in Broome County in a 1-Week Period, 1999



Data from NYSOMH Patient Characteristics Survey, 1999, Broome County
www.omh.state.ny.us/omhweb/pcs/Survey99

Appendix B

Surveys

SURVEY OF COMMUNITY-BASED PROGRAMS

1. Please provide a short description of each program offered to clients/consumers 65 years and older.
2. How many clients/consumers were treated/served during the course of the past twelve months in each of your programs?
 - a. Of these what percentage were 65 years and older?
 - b. What is the range in age?
3. What percentage of your 65 and older clients/consumers would you consider to be seriously and persistently mentally ill (SPMIs)?
4. Over the past twelve months, how many of your clients/consumers 65 years and older have been placed at an inpatient psychiatric unit?
5. Over the past twelve months, how many of your clients/consumers have been placed at a nursing facility?

Responses will be collected at the time of the interview.

Thank you for your time!

SURVEY OF INPATIENT PSYCHIATRIC UNITS

1. What is the capacity of your facility?
2. What is the average length of stay at your facility?
 - a. What is the range of the length of stay?
3. How many patients/residents were treated during the course of the past twelve months?
 - a. Of these, what percentage of your patients/residents are 65 years and older?
 - b. What is the range in age?
4. Please describe any specialized programs that you may have that are designed specifically for this age group.
5. Please describe any specialized programs that you may have that are not specifically for those 65 years and older that are utilized by this age group.
6. What percentage of your 65 and older patients would you consider to be seriously and persistently mentally ill (SPMIs)?
7. Over the past twelve months, how many patients/residents of psychiatric units have been placed at a nursing facility?
8. Over the past twelve months, how many patients/residents 65 and older of psychiatric units were discharged to facilities other than nursing homes?
9. Over the past twelve months, how many patients/residents 65 and older of psychiatric units died while in your facility?

Responses will be collected at the time of the interview.

Thank you for your time!

SURVEY OF LIVING FACILITIES

1. How many of your current residents are 65 years and older?
 - a. What is the range in age?
2. Please describe any specialized programs that you may have that are designed specifically for this age group.
3. Please describe any specialized programs that you may have that are not specifically for those 65 years and older that are utilized by this age group.
4. What percentage of your 65 and older residents would you consider to be seriously and persistently mentally ill (SPMIs)?
5. What percentage of your 65 and older residents are currently involved in mental health services?
6. How many of your current residents were referred from a Psychiatric Unit?
 - a. What percentage of these was referred from Binghamton Psychiatric Center?
 - b. What percentage of these was referred from a UHS Psychiatric Unit?
7. How many referrals have you made over the past twelve months to a Psychiatric Unit?
 - a. Which inpatient unit do you generally refer to?

Responses will be collected at the time of the interview.

Thank you for your time!

Appendix C

**Counseling/Mental Health Agencies
from
Action for Older Person's "Broome County Elder Services Guide"**

Organization	Parent Organization	Phone	Description of Services
Arthritis Foundation		798-8048	Support groups, speak with volunteers about arthritis, fibromyalgia, and scleroderma, literature available
Geriatric Mobile Crisis Unit	Binghamton Psych Center	724-1391	Screening and consultation for admission to BPC. Must be 65+ with psychiatric diagnosis to be eligible.
Brain Injury Association		625-2917	Support, information, advocacy, counseling to those receiving brain injuries before age 22 and their families
Caregiver Services	Office for Aging	778-2411	Telephone counseling for caregivers, workshops, information. Home visits can be arranged.
Catholic Social Services		729-9166	Psychotherapeutic counseling, support groups for Parkinson's disease
Community Mental Health Services	Broome County	778-1152	Extensive, short term programs for adults experiencing emotional or mental difficulties and problems in living
Crime Victims Assistance Center		722-4256	Advocacy and referrals for individuals sustaining physical injury and files a police report
Family and Children's Society		779-6206	Private counseling at office or in home. Peer in-home counseling for transition difficulties.
Griefwork: The Healing Journey	Steffensen Associates	770-7670	Information, support, and counseling for bereaved individuals
Jewish Federation of Broome County		724-2332	Counseling in framework of Jewish culture and religion
Kidney Foundation of Northeast New York		763-5122	Information, support, and counseling for those involved in dialysis and transplant
Lupus Foundation of America		772-6522	Education, counseling, and support
Mental Health Association		771-8888	Assists in finding therapists and mental health programs

Organization	Parent Organization	Phone	Description of Services
Multiple Sclerosis Society		724-5464	Counseling and support groups for MS patients and family
HOME Program	Office for Aging	778-2411	(Helping through Outreach and Mental Health for Elderly); Mental health assessment and counseling
Oxford Group Home		773-3300	Provides mental and physical awareness needs for men
Oxford House for the Older		773-3000	Housing for senior men
Samaritan Counseling Center		754-2660	Counseling on a variety of issues
Southern Tier Independence Center		724-2111	Professional counseling to people with disabilities and their families
Susquehanna Assoc. Family Counseling Ministry		771-8179	Counseling for troubled individuals and families
Crisis Center/Suicide Hotline	UHS	762-2302	24 hour hotline
Family Ties	UHS	762-2887	For family and friends of mentally ill
Veterans Affairs Division		724-1299	Information and assistance with Veterans benefits. Must be veteran or dependent
Veterans Services Center		723-8527	Services to veterans with PTSD
VA Outpatient Clinic		772-9100	Social work services for veterans
Vietnam Veterans, Organization of		692-3517	Provides counseling, assistance, information, and referral for Vietnam Veterans and their families

Appendix D

**Mental Health Programs in Broome County,
by type,
compiled by the author**

Program Type	Program	Organization	Notes
Assessment	CASA Elder Services Center Generations HOME Nurse Practitioner Geropsychiatric Consult. Svcs.	Binghamton U. Lourdes OFA UHS C Health Aging	Evaluation for long-term health care Assessment of dementia Adult and geriatric consult/couns., geriatric psychiatrist In-home assessment & short-term counseling On site consults to those in long-term care facilities
Case Management	Adult Flex Team Case Management Case Management Intensive Case Management Veterans Support Services	Catholic Charities BPC Catholic Charities Catholic Charities Vet Support Center	Assess., case mgmt, comm. living skills to serious MI Assistance reintegrating or staying in community Assist in community living Svcs for those at risk of repeated psych hospitalizations Case management, therapy, referrals, support, etc.
Community Svcs.	Adult Protective Services Choices Core Service Agency Four Seasons Club Project Uplift	Dept of Social Svcs. Catholic Charities Catholic Charities Catholic Charities MHA of S Tier	Continuing day treatment Directs services for chronically mentally ill Social setting, self-help & membership for chronic MI Homeless with MI and those at risk of becoming homeless
Counseling	Counseling Elder Counseling & Caregiver Consultation Generations Psychological Clinic	Family & Children's Family & Children's Lourdes Binghamton U.	At home or at agency Adult and geriatric consult/couns., geriatric psychiatrist Psych services
Crisis	Adult Situational Crisis Residence CPEP	BPC UHS	Intervention, meds, short-term counseling, etc. Psych emergencies, referrals
Family/Caregiver	Adult Protective Services Family Ties	Dept. of Social Svcs. UHS	Family and friends of mentally ill

Program Type	Program	Organization	Notes
Home Care	CASA		Evaluation for long-term health care
	Elder Counseling & Caregiver Consultation	Family & Children's	At home or at agency
	HOME	OFA	In-home assessment & short-term counseling
	In-Home Mental Health Management Nurse Practitioner Geropsychiatric Consult. Svcs.	Family & Children's UHS C Health Aging	Further help to CASA with chronic mental illness On site consults to those in long-term care facilities
Housing	Family Care Residential Program	BPC	Private home living, case management
	Transitional Living Services	Catholic Charities	Supervised community housing
Information	Guide to Mental Health & Related Svcs	MHA of S Tier	List of agencies
	Information and Referral	MHA of S Tier	Identify needs and refer to MH svcs; media
	Mental Health Consumer Advocacy	Catholic Charities	Helps those having difficulties with MH sys
	Self-Help Independence Project	MHA of S Tier	Educational programming and self-help services
	Self-Help Resource Center	MHA of S Tier	Directory of self-help groups
	Stepping Stone Drop-In Center	Catholic Charities	Offers MH resources in comm. (housing, tx, etc.)
Inpatient	Geriatric Mobile Mental Health Team	BPC	Screening/consult, facilitate placements outside BPC
	Geriatric Treatment Services	BPC	Inpatient care to elderly
	Inpatient Unit	UHS	
Outpatient MH	Adult Unit	BCMHD	Crisis, rehab, support, self-help, empowerment Mental Illness/Chemical Abuse Assessment, testing, outreach, HOME, meds
	Community Treatment & Rehab Center	BPC	
	MICA	BCMHD	
	Outpatient Clinic at BGH	UHS	
Peer Counseling	RSVP	Catholic Charities	Retired Senior Volunteer Program
	Senior Peer Counseling	Family & Children's	Senior volunteers provide in-home counseling
Transition	Community Preparation Unit	BPC	Pre-discharge for difficult to place patients
	CPEP	UHS	Psych emergencies, referrals
	Single Entry Case Management	Catholic Charities	Enrolls incase mgmt svcs, directs level of intervention