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**Planning mental health services for older adults: A case study
in the development and assessment of a pragmatic planning
process in an agency setting**

Weiner, Audrey S., D.S.W.

City University of New York, 1993

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**PLANNING MENTAL HEALTH SERVICES FOR OLDER ADULTS:
A CASE STUDY IN THE DEVELOPMENT AND ASSESSMENT OF
A PRAGMATIC PLANNING PROCESS IN AN AGENCY SETTING**

BY: AUDREY S. WEINER

A dissertation submitted to the Graduate Faculty in Social Welfare
in partial fulfillment of the requirements for the degree of Doctor
of Social Welfare, The City University of New York.

1993

This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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Abstract

**PLANNING MENTAL HEALTH SERVICES FOR OLDER ADULTS: A CASE
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by

Audrey S. Weiner

Adviser: Professor Irwin Epstein, Ph.D.

This dissertation addresses, within the context of a large urban mental health and social service setting, the core question of if and how an agency, without a formal planning department, would and could plan for a new service division; i.e. mental health services for older adults. In addition, the specific outcome of this agency's planning including the proposed continuum of care for older adults is also discussed.

The planning process which required eight months to complete included a computerized literature review, key informant interviews, site visits, provider and consumer focus groups, review of public documents, regulatory review and review of local demography. The largest segment of the planner's time was spent completing key informant interviews and site visits (22.9%). However, almost two-thirds of the planning time was devoted to agency internal publics including activities such as: discussion of the "plan to plan;" data

collection; participation in general administrative functions and; committees of the Agency. The goals of such interactions included the internal marketing necessary to establish the legitimacy of the population to be served (i.e. the aged), the planner as a competent member of the management team and planning as a legitimate function.

Completion of this needs assessment and planning process were operationalized as opportunities to "reflect-in-action" (Schon, 1983). In this context, means and ends are not kept separate, but rather, defined interactively as the researcher frames a situation. Planning as conceptualized in this case study begins with a series of techniques viewed as situation-appropriate with an understanding that there is an emphasis on the interactive process, a recognition that one's work involves managing multiple relationships with people who do not necessarily share his/her objectives and the premise that this approach is applicable in practice.

In analyzing the actual planning process Etzioni's (1967) mixed scanning approach combined with Ham and Hill's (1983) notion of twinning proved to be the planning model closest to that used. Parallels are also drawn between this planning model and Rein and Schon's (1977), Wildavsky's (1979) and Gergen's perspectives of policy analysis underscoring the notions of incrementalism, and the importance of the social process within the technomethodologic process.

ACKNOWLEDGEMENTS

Completing a dissertation is not a task one can do alone - it requires the support, encouragement, advice and guidance of one's Committee, colleagues, family and friends. This brief acknowledgement does not begin to adequately express my gratitude.

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But a dissertation goes beyond one's Committee. **Jacob Reingold**, the Executive Vice President of the Hebrew Home for the Aged at Riverdale, has my appreciation for his support and encouragement during those two arduous years of course work and full-time employ.

The Agency at which I am presently employed (and which remains unidentified throughout this disseration) has my respect for its commitment to quality of service, willingness to openly discuss difficult issues, ability to take risks, and my appreciation for the speed with which I was welcomed and was made to feel a part of the team. The Agency's Executive Vice President's commitment to this population is especially appreciated; the Associate Executive Vice President is owed a special expression of appreciation for his willingness to guide me through a new service sector, support a new approach to program planning and for his faith and trust that this process could work.

There is no question that not only this document but every paper submitted during these past few years would not have been possible without the support of **Mary Burns**. We worked together innumerable evenings and weekends - the accomplishment is really ours to share.

And to my family and friends who sometimes wondered if I still looked like my picture, who didn't object if we rescheduled birthdays or Mother's Day to avoid conflict with papers that were due, who continued to call despite my inability to "play" these last few years goes my love and thanks for your patience, encouragement, and your pride.

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"Each period in the life-span of man forces on him a different reality based on the altered physiology and the extent of the richness of the human spirit. Old age can become an expression of the summation of the human experience...rich, varied, colorful and in turn enriching. Conversely, it may be impoverished or empty and only serve to emphasize futility of life and its meaning to many of the old."

Weinberg, 1977

"Plans are nothing; planning is everything."

Dwight D. Eisenhower

"It must be remembered that there is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than the creation of a new system. For the initiator has the enmity of all who would profit by the preservation of the old institutions and merely lukewarm defenders in those who would gain by the new ones."

The Prince, Machiavelli

Chapter 1: Introduction

Never before in the history of the United States has mental health been a subject of greater controversy and ambivalence than it is today. The enhancement of mental health as well as the treatment of mental illness continues to represent one of this country's most pressing health issues (Miranda, 1991). Public officials and providers are concerned about its underfinancing and fear for its future. At the same time, mental health leadership realizes that there is great promise for substantially improving the lives of mentally ill patients. One of the priorities for rationalizing our present health care system (including mental health care) is ensuring a quality of life for the years that are being added, a quality that should increase the chances that the later years will be lived at the highest possible levels of independent function (German et al., 1985).

It would be unduly optimistic to assume that American political systems will be modified to accommodate the need to solve the problems of fragmentation of the contemporary mental health system - a problem which is exacerbated for the aged. As many as seven million elderly Americans may be in need of mental health services - a figure that would be considered epidemic in any other health context (Miranda, 1991).

Rather, practical solutions must be developed within existing political structures. Mechanic (1991) suggests that a viable framework for organizing effective delivery of services includes a strong organizational capacity, a core focus of longitudinal responsibilities and an ability to guide available funds.

It was in that context that this researcher was employed to develop a "Division for Mental Health Services for the Elderly," within a large, human service organization.¹ The creation of this division was supported by the Agency's administrative staff and Board of Directors and viewed as timely in response to:

- ° The aging of the population in general;
- ° The "aging-in" of the Agency's clients;
- ° The demography of the Jewish community wherein 18.1% of the population is 65+ (Horowitz & Solomon, 1991);
- ° The age of caregivers to frail elders, who are themselves often senior adults, and in need of mental health supports;

¹ The Agency, located in an urban setting, is a member of its local federation of Jewish philanthropies. Given its significant government funding, its services are non-sectarian in nature. As is described more fully within Chapter 4, the Agency provides clinic-based outpatient mental health services, residential treatment programs for children, adolescents and adults, intermediate care facilities for the developmentally disabled, volunteer programs, special Russian refugee orientation and integration programs, Jewish family life education programs, and specialized AIDS scattered site housing.

- ° The recognition that a person 40 years of age will spend 17 years bringing up a child and 18 years caring for an aging parent thus emphasizing the length of time supports may be required (Banquer, 1991);
- ° The success of existing (albeit very limited) existing Agency services to the aged, including on-site services at local Y's, family life education programs and professional education;
- ° A desire to treat the senior adult within the context of the family unit;
- ° A desire for the Agency to enhance its services to the Jewish community recognizing that attachment to one's ethnicity and a desire for spiritual connectedness may increase with age (Jakobovitz, 1988). In fact, Jews have preferred to seek and obtain services from agencies which are maintained under Jewish auspices and which maintain a Jewish identification. Such a relationship leads families to feel that care will be provided by personnel who are attuned to the totality of Jewish experience, as well as to individual religious and cultural needs (Jakobovitz, 1988);
- ° A recognition that as institutions seek to meet environmental pressures through diversification, service to a senior population is potentially a good fit within

the Agency from both an economic as well as need perspective (Evashwick, 1984).

While the Agency recognized that some planning would be required to develop this division, the manner and approach remained to be defined. This opportunity provided not only the challenge of developing a planning strategy for aging-services development and implementation in a "non-aging" host setting, but also the description and evaluation of the planning process itself. Its utility for aging-services program planners, especially those in non-aging host settings, will be in the selection of planning strategies, anticipation of potential obstacles and use of planning data for program long-range implementation and priority determination. In addition, the actual plan for service delivery may be of value to other agencies with an interest in mental health service delivery to older adults.

The observation, documentation and analysis of the planning process within the context of an agency setting provides an opportunity to address the "how and why" questions of planning strategy and design; staging; internal and external publics; data gathering; emergent problems and solutions including dynamic tensions; data analysis; plan presentation, and the relationship of the assessment and program planning process to ultimate program prioritization and development. Special attention will be given to internal publics and marketing as this process marks the introduction

of a new approach to program development in the Agency as well as a service to a population potentially viewed by staff as "less desirable" than children and families. Finally the planner's ability to and process of "reflection-in-action" (Schon, 1983) will be evaluated as one component of this study's generalizeability.

The literature review which follows is divided into two chapters to adequately address both the substance and process of this study. Chapter 2 provides an overview of the issues attendant to mental health and senior adults. Chapter 3 addresses planning theory and strategies which integrate management, marketing, industrial planning approaches and qualitative research and consequently form the basis for the needs assessment. Chapter 4 details the proposed and actual planning methodology including time frames, internal and external approaches and key informant sample. Chapters 5 and 6 focus on the specific findings including those specific to mental health service delivery to the aged and of the needs assessment and planning process as well as the technomethodologic and sociopolitical aspects of the planning process. Chapter 7 provides an analysis of the planning process and related practice principles. Chapter 8, as an epilogue traces the implementation of this plan during the first three months following its approval, that timeframe reflecting the timing of the writing this dissertation.

Chapter 2: Literature Review - Aging and Mental Health**DEMOGRAPHY**

Two millennia ago Cicero remarked that "intelligence, reflection and judgement reside in old men, and if there had been none of them, no states could exist at all." Now, with innumerable major medical and technological advances, we often regard impaired intellect, disturbed reflection and altered judgement in the elderly as natural concomitants of their age. There is probably no other group in which the interplay of psychological, social and biomedical factors influencing mental health is so obvious (Cohen, 1976).

America is, quite simply, growing older - one of the major achievements of improved disease prevention and health care in this century (Special Committee on Aging, 1990). The older population has increased far more rapidly than the rest of the population for most of the 20th century. In 1900, less

than one in twenty-five Americans was age 65 or over². In 1990, one in eight Americans was at least 65. People reaching the age of 65 in 1989 have an average life expectancy of 82.2 years (AARP, 1991).

The number of people age 65+ in the United States increased to 31.2 million in 1990, representing 12.6% of the population and is expected to increase to 66 million or 22% of the population by the year 2030 (AARP, 1991). In fact, if current fertility and immigration levels remain stable, the older population will be the only age group to experience significant growth in the next century.

The older population is itself getting older. In 1990, the 65 - 74 age group (18.1 million) was eight times larger than in 1900, but the 75 - 84 group (10.1 million) was 13 times larger and the 85+ group (3.1 million) was 24 times larger (AARP, 1991). Further, the sub-group 85+ is expected

² Senior adults are most typically referred to in three categories: those who are 65 - 74 years old (the youngest-old), those who are 75 - 84 (the middle-old), and those who are 85+ (the oldest-old). The selection of 65 years of age as the demarcation point can be traced to the 19th century in Germany where Bismark identified 65 as the age for retirement benefits. This was done on the basis of actuarial projections, rather than physiological and emotional realities. This group, i.e. the 65+, cannot be thought of in terms of homogeneous needs, but rather in relation to their mental health needs and related disability and function. The categorization of 65 for aging services is neither simple nor consistent. For example, services authorized by the Older Americans Act are for persons age 60+; aged-based Medicare reimbursed services are for persons age 65+. One goal of this planning was to define "aged" for specific older adult populations requiring mental health services.

to triple in size from 1980 to the year 2030 (Special Committee on Aging, 1990). Moreover, in the first decade of the 21st century, the 76 million children born between 1946 and 1964 - the "baby-boomers" will begin to reach the age of 60 (Special Committee on Aging, 1990). The states with the largest number of elderly citizens are California (3.1 million), Florida and New York (2.3 million) (AARP, 1991).

In 1990, there were 18.7 million older women and 12.6 million older men, or a ratio of 149 women for every 100 older men. This gender ratio increases with age, ranging from 123:100 for the 65-69 age group to a high of 259:100 for persons age 85+. Marital status is also of interest as half of all older women in 1990 were widows. There were nearly five times as many widows (8.4 million) as widowers (1.8 million) (AARP, 1991).

CO-MORBIDITY OF PHYSICAL AND MENTAL HEALTH

The aging process is characterized by the acquisition of a series of irreversible deficits that place stress on the individual. Aging is indeed a bio-psychological process, not strictly a biological one. Age-related changes can be anticipated along three dimensions:

1. Gradual decline in physiological reserves of most organ systems beginning in the fourth decade of life.
2. An increasing probability of specific age-related diseases that also contribute to the loss of physiologic reserves. Age-associated alterations and perceptual and cognitive function can be exacerbated by concomitant disease processes (Becker & Cohen, 1984; Rossman, 1980; Marsh, 1980).
3. From a social perspective, the aged are faced with different societal attitudes and confronted by a higher likelihood of losses within their support network as a function of retirement, and the death of family and friends. The passage from middle age into what is euphemistically called the "golden years" can be rewarding as demands ease and time for leisure pursuits, family and friends become available. However, losses of social role, economic security, family and friends and declining health require a mental health system adept at identifying the at-risk elderly and providing relevant services (U.S. General Accounting Office, 1982).

Becker & Cohen (1984) recognize that the emphasis with the elderly should not be to cure the disease so much as to place therapeutic emphasis on caring and social supports. Invasive procedures and reliance on medications are not the "easy answers" for older adults (Cohen et al., 1983; Hunt, 1980).

Clearly then, the interplay between social, economic, physical and emotional factors in the elderly is an area of particular importance effecting service design, delivery and utilization (Lurie et al., 1987). This includes the fact that increased longevity will result in greater exposure to the risk of chronic debilitating conditions (New York City Department for the Aging, 1986) as well as the related comorbidity between physical and mental illness.

For example, while patterns of illness and disease have changed in the past 80 years, wherein acute conditions were more prominent at the turn of the century, chronic conditions now prevail with more than 80% of persons age 65+ having at least one chronic condition. To illustrate, the rates per thousand persons age 65+ for the most common conditions effecting the aged are displayed in Table 1.

TABLE 1
Rates of Common Conditions of the Aged, Per Thousand
Persons Aged 65+

Arthritis	482.5 per thousand
Heart disease	442.9 per thousand
Hypertension	371.1 per thousand
Hearing impairments	296.8 per thousand
Diabetes	98.2 per thousand
Vision impairments	77.4 per thousand

(Special Committee on Aging, 1990).

Relatedly, 23% of those 65+ have difficulty with one or more of the activities of daily living (ADL) and 27% of senior adults have difficulty with instrumental activities of daily living (IADL). These proportions increase with age (Special Committee on Aging, 1990). It is further estimated that two-thirds of those 65+ living in the community with long-term care needs require considerable help because they are so ADL disabled (HCFA, 1987). While Garber (1988) suggests that the overall health status of a surviving older adult is not getting better and that the burden of long-term care may grow heavier as survival improves, this is a controversial subject in the field.

The above discussion relates to the aged in general. However, Lurie et al., (1987) indicate that aged patients with identified psychiatric problems are likely to have physical

health problems - in some cases causative, in others associated with their mental health problems.

From the perspective of mental health needs and service delivery, there is the recognition that while mental illness is common in older people it is often untreated (Harper, 1992). Moreover, there is little research or understanding of how, when or why older adults use mental health services (Institute of Medicine, 1991).

While social need is a soft concept that involves values (Smith, 1990), recent studies have estimated that although a significant number of elderly have mental health problems, their treatment needs have not been adequately addressed (Spore & Atchley, 1990; Lebowitz et al., 1987; Raschko, 1985; Smyer & Pruchno, 1984). The losses that occur throughout life tend to cluster in the later years. Cumulative losses may exacerbate pre-existing mental health conditions or trigger the onset of new disorders. It follows then that the elderly of our society are at great risk of experiencing mental illness. In fact, estimates of mental illness in the elderly range from 13% to 25% of the population over age 60 (Fleming et al., 1986).

**ESTIMATES OF PREVALENCE AND INCIDENCE OF MENTAL ILLNESS
IN THE AGED**

The Epidemiologic Catchment Study (ECA) supported by NIMH during the early 1980's is a useful reference as it is a population-based study conducted in five communities (New Haven, Baltimore, St. Louis, Durham and Los Angeles) that added samples of elderly persons in three communities to enable estimates of mental illness in the elderly. The lengthy interview was the Diagnostic Interview Schedule (DIS); a structured questionnaire designed for use by non-clinicians. The data was passed through a computerized algorithm to generate DSM-III diagnoses and scores for the Mini-Mental State (Shapiro et al., 1984). The overall estimate of the prevalence of mental illness in that study for one month was 12.3% in the elderly population, with the most frequently occurring conditions being: anxiety disorders (5.5%); severe cognitive impairment (4.9% total with 2.9% for ages 65 - 74; 6.8% for 75 - 84 and 15.8% for those 85+); phobias (4.8%), and affective disorders (2.5%) (Harper, 1992) (Table 2).

TABLE 2
MENTAL DISORDERS AMONG OLDER ADULTS

Category of illness	Distribution of psychiatric diagnoses (%)	
	Community residents ^a	Medical/surgical inpatients ^b
Cognitive impairment	4.9	30.2
Affective disorders	2.5	18.5
Anxiety disorders	5.5	5.2
Alcohol abuse/dependence	0.9	2.6
Schizophrenic disorders	0.1	0
Somatization	0.1	0
Personality disorder	0	8.3
Other psychiatric disorder	0	7.9

a Adapted from Regier, et al., 1988.

b Adapted from Rapp, Parisi & Walsh, 1988.
(Spar & LaRue, 1990)

Differences between this rate of 12.3% and higher estimates have been attributed to the inadequacy of conceptual frameworks that have been used for longitudinal research study, lack of inclusion of relevant service sites (e.g. respite, adult day care, home care); errors in case sampling; sample size; outcome criteria; statistical analysis and the

need to redefine and broaden the definition of depression in older adults (Burvill et al., 1991; Murphy, 1991).

Consequently, other prevalence estimates, based in programs and clinical experience are also useful for planning. Table 2, in providing a comparison between aged community residents and medical/surgical hospital inpatients, underscores the issues of co-morbidity and the importance of linkages between the typically disparate medical and mental health care systems. Other studies provide further background.

- ° At Philadelphia Geriatric Center's congregate housing facilities, 5.3% of the residents have a major depression and 21.3% have other depressive disorders. These figures exclude individuals with depression as a complication of dementia and therefore underestimate the magnitude of the problem (Parmelee et al., 1989).

- ° In an elderly outreach program developed in Iowa and designed to identify homebound individuals age 55+ in need of mental health care, depression was identified in 15.2% of the clients.

- ° In the Spokane (Washington) Elderly Services Program, 57% of the 720 elderly clients admitted to their multidisciplinary, in-home evaluation, treatment and case management program had "emotional depression" (Rashko, 1990).

° In the Mature Adult Counselling Center for adults aged 55+ and their families provided by the Department of Aging and Mental Health of the Florida Mental Health Institute, diagnoses of the 164 clients admitted between July 1, 1987 - December 31, 1988 included:

- ° Dysthymia - 29%
- ° Adjustment disorder with depressed mood - 20%
- ° Marital problems - 10%
- ° Depressive disorder NOS - 4%
- ° Major recurrent depression - 3% (Speer et al., 1991a)

In 1985, 12% of the United States population was age 65+ but committed 19.7% of all identified suicides (Staebler, 1991), reflecting the seriousness of the problem and the synergistic effect of the aged's increasing degree of despair (Miranda, 1991). Specifically, the rates of suicide in 1990 of the aged in comparison to the rate for individuals age 15 - 24 years are as follows:

<u>Age Group</u>	<u>Rate</u>
15 - 24 years	13.6 suicides/100,000 persons
65- 74 years	18.1 suicides/100,000 persons
75 - 84 years	26.1 suicides/100,000 persons
85+	22.5 suicides/100,000 persons

Divorced and widowed men (especially as it relates to those individuals living alone and/or who are bereaved) show the highest suicide rates among the elderly (Associated Press, 1991) with additional risk factors including recent illness or physical changes, social and economic status (Conwell et al., 1990; Bromberg & Cassell, 1983) and affective psychopathology (Carlson, 1984).

A perplexing trend in the suicide rate of individuals age 65+ has emerged. After a half century of decline, that rate has been steadily increasing since 1980 (Osgood, 1990). Researchers have offered several explanations for the decline between 1930 - 1980 including:

- ° An increasing proportion of women at older ages who are less likely to commit suicide than men;
- ° The financial status of the elderly which has improved greatly from 1930 - 1980 with the passage of Social Security, Medicare, and the Older Americans Act.

However, Osgood (1990) suggests that it is too early to explain the changes in the last decade. One possibility is that coroners are collecting better data in contrast to the fact that the rate is real and one has to attribute societal conditions to that change. In addition, there is the possibility that advanced medical technology has greatly extended life and may also be prolonging suffering with suicide being viewed as a choice. In addition:

- ° Older adults fear Alzheimer's disease and other debilitating illness.

- ° The political and economic changes in the '80's including cutbacks in food stamps and social programs and threatened reductions in Social Security, Medicare, and Medicaid have created a situation where some elderly are fearful of losing what little finances, dignity and personal control they have.

- ° There is increased social acceptability of suicide as a solution for the problems of older adults and a perception that there is a right to die. Death with dignity, and rational suicide are part of an increasing societal acceptance of suicide. Not only does it release society from the responsibility of confronting the issue, but this also sends a powerful message to older adults who may already feel isolated, unloved and unwanted (Associated Press, 1991; Osgood, 1990).

An "exhaustive search for statistics" by Saul and Saul (1988-1989) concerning suicides by the elderly who are residents in nursing homes reveals a striking lack of information. It is suggested that familial, social and bureaucratic attitudes combined to make institutions very sensitive about the possibility of suicide (Saul, 1983) and hence very reluctant to address it clinically, programmatically and/or in a preventive, positive manner.

THE CURRENT SERVICE DELIVERY SYSTEM

Despite the estimates that between 13% - 25% of older Americans suffer from some form of mental illness, and the fact that the elderly account for 12% - 13% of the population, mental health services are obtained in very limited fashion by older adults:

- ° 5% are "admitted" to psychiatric emergency rooms;
- ° 7% receive inpatient psychiatric care;
- ° 6% receive services through the community mental health care system;
- ° 2% receive services through private mental health practitioners (Butler et al., 1991; Downey, 1989; Saxon, 1989; Light et al., 1986; Waxman et al., 1984).

Shapiro's et al. (1984) assessment of unmet need as part of the Baltimore sub-sample of the ECA study concluded that individuals age 65 and over had less need for service (which included actual service users plus those individuals self reporting two or more manifestations of emotional need during the structured interview), but the percentage who **did not have their needs met was exceptionally high (62.2%)**. Within this sample, higher proportions of need were identified by women, non-whites and persons living alone ($p < 0.01$).

Tischler et al. (1985) assessed the New Haven ECA sub-sample giving particular attention to whether limited use of the mental health specialty sector by the elderly was a

function of decreased prevalence of psychiatric disorders. When the study team first controlled for psychiatric status, lower mental health services use was not the result of the decreased prevalence of psychiatric disorders or lower rates of distress. Rather, those persons age 65+ were more likely than any other age group to visit a physician within the previous six months (64.8% used this sector; $p < .05$). Senior adults were the only age group more likely to visit medical practitioners when dealing with "nervous or emotional problems."

Further, 11.1% of the total sample in New Haven reported taking medication for such nervous or emotional problems during the preceding six months with 16.7% (11.1% were taking minor tranquilizers, and 6% were taking sedatives or hypnotics) of the 65+ age group reporting such medication use - the highest of any age group ($p < .001$). The number of persons 65+ reporting medication use was over three times as great as the number who reported mental health related contacts with either health or mental health care providers in the past six months. Concerns were expressed that medication rather than counseling was used and that general practitioners are notoriously poor in identifying mental health needs. Further, the study concludes that the aged were using psychotropic drugs in ways not envisioned by the original prescriber.

Blixon and Lion's (1991) study of 25,447 mental health visits to hospital-based clinics including psychiatry, substance abuse, adult medicine, etc., in New York City concluded that the low income elderly in New York City are finding their way to psychiatric clinics more easily than middle income elderly are accessing mental health services in the private sector. They note a heavy concentration of major and minor disorders and a significant proportion of substance abuse suggesting an elderly population with more severe psychiatric problems than was anticipated.

TABLE 3

**Psychiatric Visits by Age and Category
New York City Hospital-Based Outpatient Clinics**

(N = 25,447)

Mental Health Disorders	Young (25-44 yrs) (N = 15,890)	Mid (45-64 yrs) (N = 7,735)	Old (65+) (N = 1,832)	Total
Substance Abuse	49.4%	40.7%	9.1%	43.9%
Major (non-organic psychosis, mood disorders)	19.3%	24.5%	30.5%	21.7%
Minor (neurotic, behavioral, adjustment reactions)	28.8%	33.1%	50.9%	31.7%
Organic	0.4%	0.6%	8.7%	1.0%
Other (social, medical, legal)	2.1%	1.1%	0.8%	1.7%

Recognizing the 1990 change in Medicare mental health benefits wherein psychologists and social workers not in a physician-directed setting can now receive reimbursement for service provision, Blixon and Lion (1991) speculate about whether there will be increased competition for this market segment and how responsive the elderly might become to being consumers of mental health care. It is clearly too early to understand the impact of this regulatory change.

Currently, less than 3% of all Medicare funding is spent on mental health services for the elderly, another reflection of the underutilization of and lack of access to mental health services by this age group (Binney & Swan, 1991). Evidence demonstrates that the mental health needs of the elderly remain underaddressed (Talbott, 1985), mired in narrow disciplinary battles dominated by the hegemony of biomedicine (Binney & Swan, 1991). There are those in need who could be served in a manner which would allow them to remain in the community where life would have quality to it. Comprehensive community-based mental health services were suggested in 1977 by Weinberg as one answer. Clearly, this has not happened.

Much has been written about the need to recognize that the elderly are affected by the same spectrum of psychiatric disturbances as are younger people, but that the risk is greater (Eisdorfer, 1977). As Lebowitz (1988b) has pointed out, the gap between the need for services and the utilization of services has become more obvious as increased geriatric

research has identified the full range of serious disorders and emotional problems from which the elderly suffer. In spite of the high prevalence of mental health disorders in old age, community-based mental health services for the aged are basically inadequate, fragmented, unaffordable and seldom used (Harper, 1992). Even many mental health professionals are unaware of the unique problems of older adults and of current developments within the field (Hinrichsen, 1990).

Moore et al. (1984) describe a retrospective chart audit of clients seen in the Older Americans Resources Services/Geriatric Evaluation and Treatment Clinic (OARS/GETC), a multidisciplinary geriatric outpatient clinic evolving from Duke University's Aging Center's information and counseling service for older adults. They noted a high incidence of unrecognized dementia and a reluctance by patients and their families to identify mood or memory problems as their chief complaint. In 1982-83, medical clinicians evaluating patients with a "medical" problem diagnosed psychiatric problems in 80% of the clients (including 28% with depression; 45% with dementia and 8% with depression and dementia). The study concludes that there is a substantial demand for combined medical and psychiatric evaluations.

There is growing evidence that mental health care actually results in lower total health care use and costs for treated persons. This can be the result even when the cost of mental health care itself is included (Holder & Blose, 1987). Studies by Mumford et al. (1983) and Holder & Blose (1987), found that older adults had greater offset effects following mental health treatment than did younger people. There are significant policy implications given the tendency of older adults to use more medical care services than younger groups including more expensive hospital care (Holder & Blose, 1987). Yet despite the clear clinical and cost implications of greater linkages between medical and mental health systems, it is the general health sector that currently functions as the "de facto" mental health service system for the elderly (Schurman et al., 1985).

Burns and Taube (1988) note that only 37% of the elderly in need of mental health services receive them. Moreover, only about one-third of the elderly in need receive help from the mental health sector.

As indicated, when older people do seek help, usually it is a visit to their primary physician and the disorder is in the guise of some physical problem or complaint (Horgan, 1985; Shurman et al., 1985). Attempts at treatment of such patients have been unsuccessful or at best temporary, resulting in additional visits for a recurring or different complaint (Waxman et al., 1985). Further, there is evidence of the lack

of recognition of the presenting mental health issue, unnecessary and prolonged treatment including unnecessary testing and expense, limited referrals and inappropriate prescribing of psychotropic drugs by general practitioners (Harper, 1992; Staebler, 1991; Wilkinson, 1986). In addition, there is the added risk of iatrogenic disorders and dangers associated with failure to treat depression (Waxman et al., 1985). Further, as an extreme indication of the inability to meet senior adults' needs, three-fourths of the elderly who commit suicide visit their doctor one month before their death (Wasylenki, 1982). When aged reach out to the health care system, it fails to meet their needs.

Access to service and intent to use services are far from uniform and/or consistent among the elderly in general. Service use is generally higher among women age 75+, widows living alone, persons with poor health and persons with limited informal social resources (Krout, 1983; Harel et al., 1983; George, 1981). In addition to these objective indicators, knowledge about access to services and an attitudinal predisposition toward use are also important variables (Harel et al., 1983).

Clearly, the mental health needs of older adults are not being met; understanding both the needs and the barriers to treatment are critical if one is to plan and design an effective service model.

BARRIERS TO SERVICE USE

The barriers which most typically prevent senior adults from accessing appropriate mental health services can be broadly classified within three domains: financial; human resource and, system-based.

A. Financial

Both Medicare and Medicaid place rigid restrictions on mental health benefits for the elderly. This includes restrictions of the provision of needed outreach and educational services (Biegel et al., 1989), and the current 50% co-insurance Medicare requirement for clinical social work services (National Council of Community Mental Health Centers, 1989). The inflexibility and fragmentation of funding between the public mental health, health, aging and social service networks exacerbates this problem (National Council of Community Mental Health Centers, 1989). Further, the aged often wish to avoid the financial consequences and disdain of public aid (Moen, 1987) minimizing their access to Medicaid-supported mental health services.

B. Human Resource

There is a lack of public awareness of aging services as a career opportunity leading to an insufficient pool of workers to fill current jobs and an inadequate number of workers "in the pipeline" for most job titles (Commission on Aging Services for the Year 2001, 1992). Anecdotally, this has been noted to be especially true in clinical social work, psychology and psychiatry. Secondly, there is a clear problem recruiting individuals who are knowledgeable in psychogeriatric issues (Buckwalter et al., 1991; Butler, et al., 1991). In addition, the National Council of Community Mental Health Centers (1989) suggests difficulties in recruitment as a function of lower pay scales in the mental health service delivery system as compared to the acute care and long-term care sectors.

C. System-Based

In a study of senior center/luncheon site participants, Waxman et al. (1984) found that 88% of the individuals would seek help from their general practitioner for a psychiatric problem. Only 19.2% felt that any mental health provider

would be effective for depression. There is a clear bias against mental health professionals for which there are a series of possible explanations. Stigma is a core impediment on the part of both the client and the therapist. There is a great deal of stigma on the part of the elderly to seek mental health services from mental health providers. Older people no longer feel capable or worthy of being helped having incorporated a negative cultural view of themselves (Butler et al., 1991; Hagebak & Hagebak, 1980). There is an acceptance by the elderly of societal stereotypes about aging in which coping problems and problems of living are viewed as the normal and irreversible results of senility and growing older. This is often combined with the exaggerated self-reliance ethos of our society (Speer et al., 1991b; Brody, 1985; Lasoski & Thelen, 1987). While the notion of stigma is prevalent in all age groups, it is the most pronounced for the aged (Commission on Aging Services for the Year 2001, 1992; German et al., 1985).

Additionally, the elderly may be reluctant to review symptoms such as forgetfulness or confusion for fear of institutional placement (Butler, 1975) or fear their further deterioration or death (Gaitz

& Varner, 1980). Family members may compound this denial by refusal to admit that their elderly relative may have a psychiatric disorder (Gaitz & Varner, 1980).

In comparison to younger age groups, the oldest-old are less informed about basic availability of mental health services (Lasoski & Thelen, 1987). They lack accurate knowledge concerning the services that psychiatrists, psychologists, social workers and counselors provide and thus may not consider them as viable helpers (Woodruff et al., 1988).

Brody and Kleban (1981) determined that aged persons are often unaware that chronic emotional illness and symptoms are treatable. Many elderly persons grew up in a time when mental health services to the public were largely provided at insane asylums. Care was custodial rather than treatment oriented (Kiernat, 1984). These persons were middle aged before the concept of community mental health was realized and outpatient services were available (Woodruff et al., 1988).

Critics have suggested that the real fault for underuse lies in the attitudes and practices of providers. In general, most elders are viewed as having lived out their useful life span and are

thus less deserving of time and resources than younger persons (Binney & Swan, 1991; German et al., 1985). In addition, Waxman et al. (1984) suggests that there is bias against treatment as well as "ageism"³. Gaitz (1974) has suggested that many professionals view aging as an inevitable decline and deterioration in function. Some also believe that mental disorders among the elderly are not "true" illnesses and that custodial care is what older people really need. There are those who believe that the elderly are too old for therapy because they are resistant to change, untreatable due to arteriosclerosis or senility, are boring and garrulous, and generally poor candidates for psychotherapy (Butler & Lewis, 1982; Ford & Sbordone, 1980; Gaitz & Varner, 1980; Butler, 1975).

Butler (et al., 1991) suggest that these biases stem from transference issues regarding a professional's own aging and conflicts elicited regarding a therapist's feelings about his/her own parents. In addition, the patient could die during treatment which would be a narcissistic blow to the therapist and/or the therapist's colleagues may not

³ Ageism is the term first used by Butler in 1969 to describe the biased values that this youth-oriented culture holds concerning the elderly.

support the therapist's work with the elderly
(Group for the Advancement of Psychiatry, 1971).

From the practitioner's perspective, Ronch and Maizler (1977) take issue with Freud's (1959) statement that cure with elderly patients would be reached at a time of life when "much importance is no longer attached to nervous health." They raise the question of "whether older people are no longer educable" (Fuchs, 1975) and, more importantly, whether mental health professionals are.

Fellin and Powell (1988) indicate that among older adults, ethnic minority persons are even more severely underserved. The barriers obstructing minority use of mental health services include those noted above as well as acceptability and accessibility including cultural, educational and linguistic barriers. This includes, for example, an understanding about the cultural heritage of older adults and the meaning of health and illness within their cultural context. This impacts upon interactions with the mental health professional as well as willingness to follow a medication regimen (Raffoul & Haney, 1989).

Two recent policy changes effect the placement of individuals in nursing homes with behavioral problems as well as the care of individuals with dementia in the community. The requirements of the 1987 Federal OBRA regulations mandate the screening of individuals requiring active treatment for

psychiatric illness with the intention that this group of patients would be admitted to mental health institutions and those with dementing illnesses to nursing homes (New York State Department of Health, 1990). As a consequence, admission to psychiatric facilities for all individuals whose primary cause of disruptive behaviors is organic and who do not require active psychiatric treatment becomes almost impossible. In addition, there is concern that prospective nursing home patients will be denied physical care because institutions cannot provide for their mental health care needs (Binney & Swan, 1991).

In addition to the problems noted above, there are very practical barriers to the accessing of mental health services by the elderly. This includes actual physical barriers (e.g. mental health programs which are not handicapped accessible and require older adults with walkers to negotiate narrow stairways), and limited transportation systems.

Finally, organizational structures often relate more to funding stream and regulatory demands, bureaucratic empire building and less to collaboration, cooperation and even the "sharing of clients" that is necessary to facilitate the use of mental health services (Buckwalter et al., 1991; West & Applegate, 1989; Biegel et al., 1989; Estes, 1979). Lebowitz (1988a), in fact, correlates the underuse of community mental health services by older adults with limited coordination with area agencies on aging, staff trained in mental health

services to the elderly and specific services for older adults.

Growing competitiveness among human services providers for the same dwindling financial resources is also noted as a systemic barrier (Biegel et al., 1989). In today's financial climate, the negative impact of waiting lists for services must also be acknowledged as a barrier to service (Wallace, 1990).

Lurie et al. (1987) write about integration of physical health, mental health and long-term care systems thereby facilitating earlier and more appropriate intervention for both physical and mental health problems. Yet they recognize that the call for integration is not new and suggest that in the absence of intersystem integration, the mental health system might assume the lead in targeting high-risk populations within the following sub-groups:

- ° Those with a history of mental or physical illness in early life;
- ° Those who consult physicians for persistent symptoms not attributable to a physical disorder after differential diagnosis;
- ° Those who have recently suffered from bereavement or other social or economic losses;
- ° Those with chronic or serious physical illness in late life.

Finally, Harper (1992) reminds the service planner that the availability of mental health services does not mean access to quality care.

SPECIFIC MENTAL HEALTH DISEASE ENTITIES

Depression

"The ability to think, to feel, to interact with others, to share a sense of purpose, to work, to love, to experience gratification, to care for others, and to maintain self responsibility are precious human attributes that elderly people strive to maintain. In few circumstances are these elements of our experience and capacity so broadly and deeply challenged as with depressive disease.

"What are the consequences of failure to recognize and treat depression in elderly people? Many of our senior citizens will live their final years in despair and suffering without any appreciation of their affliction or the understanding and comfort of those most dear to them. Professional help is not often sought or offered, and depression is not likely to be brief. The likely consequences are loss of personal happiness and severe strain on living circumstances. Depression may trigger a shift from home to a nursing facility or may shift the person from a warm and respected friend or loved one to an isolated individual with lost status. Untreated depression costs money because physical illnesses require more medical services, living arrangements become institutional, and employment is lost. These costs should be substantially preventable with presently validated case recognition and treatment techniques... personal benefits of symptom reduction are well documented and compelling." (National Institutes of Health, 1991)

Perhaps more than with younger adults, the medical, psychological and social context surrounding geriatric depression often influences the prognosis of older patients.

Thus, rather than considering depression as a single entity in the geriatric population and recognizing the diagnostic complexities involved, Sunderland et al. (1988) recommend the subdivision of the symptoms of depression in the older adult into three major areas:

1. Major affective disorders in the elderly;
2. Depression associated with medical illness in the elderly;
3. Sadness and depression associated with the life cycle.

There is the continuing myth that the elderly have a higher incidence of major affective illness than any other age groups. In fact, the current epidemiological estimates indicate that rates for major depression are somewhat lower in older adults (approximately 2%) than in younger adults (3% - 5%) (Blazer et al., 1987b; Klerman et al., 1985).

It is further suggested that while only approximately 2% of the elderly suffer from a major depression, an additional 6% suffer from moderate depressive disorders and an additional 19% from dysphoria (depressive symptoms or "misery in various degrees") (Hunt, 1991).

Major depressive episodes may be less prevalent but have greater consequences in late life. The probability of recovery is lower for older adults compared with younger patients, with the worst prognosis for the elderly with recurring or chronic depression (Bliwise et al., 1987; Mann et

al., 1981; Zis & Goodwin, 1979). The poor prognosis may be due, in part, to the greater risk in older age for adverse reactions to psychotropic drugs (Salzman, 1985; Davison, 1978).

The rates of major or minor depression among the elderly range from 5% in primary care clinics to 15% - 25% in nursing homes. The rates of new cases of depression in nursing homes are striking; 12.6% of residents develop a new episode of major depression over a one year period and another 18% develop new depressive symptoms (National Institutes of Health, 1991).

Researchers and clinicians are beginning to note special features of late life depression. Patients who meet the criteria for primary unipolar depression with onset after age 60 are more likely to have delusions than depressed patients with early onset (Myers et al., 1984a). Gurland (1976) notes increases in anxiety, somatic concerns or hypochondriasis, loss of concentration and memory problems in older depressants. Blazer et al. (1987a) also suggest that sleep difficulties are more pronounced among the elderly with depressive symptomatology.

Many medical conditions such as coronary artery disease, endocrine abnormalities, neurological disorders, metabolic disturbances and cancer have been associated with depression (Sunderland et al., 1988). In fact, the only factor which emerges in studies as a significant predictor of a depressive

disorder is poor health. This relationship is true at all ages, but particularly relevant in late life (Bliwise et al., 1987). (See Table 2.)

In addition to the reasons noted above, the treatment of depression in the elderly is critical as the lifespan of persons with depression is shortened. Suicide, violent death as well as increases in the rates of death from natural causes (cardiovascular, respiratory, neurological) are noted (Gurland, 1991; Murphy, 1991; Sims & Prior, 1978). Further, attitudes and feelings that do not add up to clinical depression but are reminiscent of some of its symptoms also contribute to the risk of mortality, e.g. feelings of uselessness (Grand et al., 1990).

Treatment of Depression

The goals of treatment for depression include:

1. Decreasing symptoms of depression;
2. Reducing risk of relapse and recurrence;
3. Increasing the quality of life;
4. Improving medical health status;
5. Decreasing health care costs and mortality.

The two major categories of treatment of depression include biological therapy (e.g. pharmacotherapy, electroconvulsive therapy) and psychosocial therapy (National Institutes of Health, 1991).

There is now evidence from more than 25 randomized, double blind trials that antidepressants are more effective than placebos in the treatment of acute depression. In these studies, approximately 60% of the patients clinically improved, yet many of them retain significant residual symptomatology. The available information from such randomized controlled trials in the elderly is meager compared to that for younger age groups. Relatedly, the number of patients in research studies drops off sharply after the sixth decade of life and consequently, there are very few studies of the treatment of depression in the very old (National Institutes of Health, 1991).

"Most of the antidepressants are thought to be equally effective in elderly adults. The most commonly used in studies of antidepressants have been Nortriptyline and Desipramine because they have a more favorable side effect spectrum than traditional antidepressants such as Amitriptyline and Imipramine. Most clinicians avoid these latter two medications because they cause significant orthostatic hypertension which can cause falls and fractures, and because elderly patients are especially sensitive to their anticholinergic, cardiovascular and sedative side effects. Significant antidepressant response in elderly patients often occurs later than in younger patients and requires at least six to twelve weeks of therapy." (National Institutes of Health, 1991)

Medication compliance by older adults is especially important and difficult. Tideiksaer (1983) estimates that one-third of the elderly never comply with prescribed regimens, one-third comply partially, and one-third fully comply. Joyner et al. (1983) use 50% as a mean compliance rate. This degree of non-compliance must alert the mental health practitioner to the need for continued and individualized attention and follow-up.

Electroconvulsive Therapy

Electroconvulsive Therapy (ECT) has a special role in the treatment of late life depression. While age does not constitute a particular indication for the use of ECT in major depression or other diagnostic groups, the accepted indicators for ECT are such that they are particularly likely to be satisfied by the elderly depressed patient. These include:

- ° A history of poor response to or intolerance of other antidepressant treatments.
- ° A history of good ECT response in previous episodes.
- ° Situations in which the risks of other antidepressant treatments outweigh the risk of ECT.

- ° Situations in which there is a particular need for rapid and definitive clinical response due to the patient's medical or psychiatric status and/or preference.

- ° Heightened urgency resulting from a refusal of sustenance, psychosis, or suicidality which are features of the depression (Sackheim, 1991).

The evidence for the short-term efficacy of ECT is strong. It has resulted in decreased chronicity, decreased morbidity and possibly decreased rates of mortality (Wesner & Winokur, 1989; Babigan and Guttmacher, 1984; Avery & Winokur, 1976). However, relapse after effective ECT is frequent and alternative treatment strategies, including maintenance ECT or maintenance antidepressants post ECT require further study (National Institutes of Health, 1991). ECT is often described as safer than antidepressant medications, particularly among the frail elderly (Benbow, 1989; Weiner, 1982). With ECT, cardiovascular complications are the leading cause of mortality and significant morbidity. While the data are very limited, it is commonly opined, that pre-existing cognitive deficits are a risk factor for more pronounced ECT-induced cognitive effects (Sackheim, 1991).

Psychosocial Treatments

A comprehensive system of care necessitates the inclusion of psychosocial treatments because of the broad range of functional and social consequences of depression in older adults. Some patients will strongly prefer non-biological interventions and others will not be suitable for biological treatment because of side effects, interactions between drugs and co-morbid medical conditions (National Institutes of Health, 1991).

There are few controlled studies on the efficacy of psychosocial interventions with older adults dealing primarily with cognitive behavioral therapy, behavioral therapy, interpersonal therapy and short-term psychodynamic therapy. These treatments are all moderately effective and have durable effects with outpatient volunteers in comparatively good physical health. There are no clear comparisons with placebo or pseudo-treatment control groups, with the old-old, or with the medically ill elderly (National Institutes of Health, 1991). However, Blazer (1990) cautions the therapist that disordered communication is a critical problem between professionals and older adults. It derives from a number of problems that span the biologic, psychologic, and social domains.

For example, sensory deprivation including hearing loss, visual problems and the problems of "themes" must be considered. It is noted that when the older person is

isolated or lonely, an illness can not only be a "pain" but also a blessing as it provides acceptable parameters via which to complain about ailments and to recount in exhausting detail problems of physical function (Blazer, 1978).

There is reason to anticipate that psychotherapeutic approaches with proven effectiveness in younger adults can be extended successfully to the older adult, based on prior findings that the potential to benefit from psychotherapy remains undiminished by increasing age (Neimeyer & Weiss, 1990; Knight, 1988). Indeed a number of analyses have indicated that older adults may show better treatment compliance, lower drop-out rates and a more positive response to psychotherapy than younger aged populations (Brink, 1979; Sparacino, 1978-79).

While few empirical studies have been done to evaluate either the general or specific outcomes of psychosocial treatment in elders (Bliwise et al., 1987), it is the work of Gallagher and Thompson that is the primary source of empirical information in this area:

1. Psychodynamic therapy is clinically efficacious with elderly depressed patients.
2. Its effectiveness is equal to that of cognitive behavioral therapy in the acute phase of treatment and generally also in its longer range impact (Thompson et al., 1987; Steuer et al., 1984; Gallagher & Thompson, 1982; Gallagher, 1981).

A particular approach to psychodynamic therapy that bears mention because of its specificity to the elderly is that of emphasizing the psychodynamic concepts of life review and reminiscence (Lewis & Butler, 1984) which has demonstrated encouraging results with individuals suffering from mild to moderate depression. However, Niederehe (1991) offers a cautionary note with regard to the consequences in clinically depressed patients, particularly those with obsessive tendencies, low ego strength or a life history unlikely to be amenable to a positive life review.

Another perspective on the psychosocial treatment of depression is provided by Dellon and Winston (1989) who note that traditional theories of personality and intervention fail to address the needs and circumstances of the elderly client in important ways. Most theories, they suggest are developmental in perspective, but they are hard to apply to the aged because development and old age are commonly perceived as contradictory. Development implies a future and positive change; old age often connotes negative change and death.

They suggest that constructs from role theory and Erikson's psychosocial theory of development are congruent in the treatment of the elderly with depression in that:

- ° Both stress the importance of interaction for development.
- ° Neither is dependent on intra-psychic change strategies.
- ° Both provide the clinician with flexibility and a recognition that innovation is possible.
- ° Both highlight that all people - including the elderly - have a need for a positive self image, connections to valued others and the capacity to cope and adapt to inevitable life changes for optimal mental and social functioning.

Further, role theory addresses the real lack of roles for the elderly in our society and implications of that void. It is not pathology oriented which may make it less stigmatizing and a more acceptable approach to elderly clients.

Finally, Dellon and Winston (1989) conclude that there is a tendency to point toward directive and short-term treatment plans, which again may prove more attractive to the geriatric population, who are reluctant to undergo treatment. Role theory, offers a way to understand the social experience of aging and its implications. Accurate assessment, the acknowledgement and identification of stressors inherent to aging, the relationship of role status (typically losing roles and/or replacing them with lower status roles) are suggested as realistic approaches. In theory, there is a fit between the client's own understanding of his/her role and others'

expectations of his/her enactment which should be assessed and may be a source of stress.

Dementia and Depression

While there are variations in estimates of the numbers of individuals with dementia among researchers depending upon methodology and clinical criteria, it is suggested that more than 10 million individuals in the United States have symptoms of dementia (Harvard Medical School, 1985). Alzheimer's disease (the most common of the dementing illnesses) is the fourth leading cause of death in adults in the United States. An estimated 1.5 million Americans suffer from severe dementia - that is, they are so incapacitated that others must care for them. An additional one million to five million persons have mild to moderate dementia (Office of Technology Assessment, 1987). A recent study by Evans et al. (1989) indicated that of those over the age of 65 years, an estimated 10.3% had probable Alzheimer's disease, with the prevalence rising to 47.2% for those 85 and over. These authors conclude that clinically diagnosed Alzheimer's disease is a common condition, and that its impact will continue to increase with the increasing longevity of the population. While more than 70 different conditions can cause dementia, Alzheimer's disease is estimated to account for approximately 54% of these diseases (Katzman, 1986).

Alzheimer's disease and related disorders victims suffer progressively increasing impairment of memory and other intellectual abilities. Although the problems may initially be manifested in such ways as forgetfulness, poor judgement, or difficulty making calculations and handling money, the cognitive losses ultimately leave the person confused, disoriented and incapable of communicating normally. Affected individuals may undergo personality changes that range from apathy and social withdrawal to quarrelsomeness and agitation, and frequently display various emotional reactions to their illness such as depression, anxiety or suspiciousness. Other symptoms such as disturbed sleep, hallucinations, delusional ideas or a tendency to wander aimlessly are also common. Over time, these individuals lose their ability to carry out their customary everyday activities and to be responsive for their own well being. Eventually, they may lose elementary physical abilities such as bladder and bowel control, and become totally dependent on others to provide for their personal needs and safety (Advisory Panel on Alzheimer's Disease, 1989; National Institutes of Health, 1990).

Psychiatric intervention can have a critical role in the treatment of Alzheimer's disease because the predominant symptoms are behavioral in nature (Reifler et al., 1986). The morbidity for depression compounding dementia is clearly higher than that of dementia alone - that is, it is an excess disability. Reifler et al. (1986) reported that 30% of those

diagnosed as having Alzheimer's disease via extensive medical, functional and neuropsychological assessment also met DSM-III criteria for a major depressive disorder. In addition, an equal number and often higher proportion of patients exhibited depressive behaviors such as tearfulness, feelings of worthlessness, suicidal ideation and lack of interest in previously enjoyed activities (Teri et al., 1989). This excess disability has been reported to create more significant impairments in ability to perform activities of daily living (Pearson et al., 1989). Depression may well exacerbate cognitive and functional impairment and successful treatment may have the added benefit of alleviating functional distress (Teri & Umoto, 1991).

A pilot study by Teri & Umoto (1991) of four patients with Alzheimer's disease and their caregivers who met with a doctoral level clinician to determine what activities were still realistic and pleasurable, helped to determine a caregiver plan and to carry out these activities throughout the course of treatment (eight sessions). For each of these four patients a significant relationship was found between depressed mood and the frequency and duration of pleasurable activities. That is, the more frequent and longer the duration of pleasurable activities, the less depressed the patient's mood. The primary caregiver of each patient was successful in increasing the frequency and duration of pleasurable events and decreasing the patient's level of

depressed mood. The results also suggest that caregivers who are depressed prior to treatment can also benefit by such an intervention in that their own depression was also decreased.

Teri and Umoto (1991) recognize the preliminary nature of these results given the small sample size but note that this very structured intervention does provide a means by which to reinvolve the patient in pleasurable activities and enlist the caregiver with rehabilitative efforts that can be carried out in their home environment.

Anxiety Disorders

Anxiety disorders have received little attention in the literature of mental health and the aged. Consistent with the rates in the ECA studies, Uhlenhuth et al. (1983) study of the prevalence rates of anxiety disorders in the elderly indicated that 7.1% of those age 65-79 suffered from such disorders. While individuals age 65+ are less likely than young and middle-aged adults to suffer from such anxiety disorders (Myers et al., 1984b) such problems should not be dismissed from the diagnostic armamentarium of aging mental health providers.

Specifically, the rates are typically higher among women (Himmelfarb & Murrell, 1984). However for men, the symptomatology is generally more physical with greater mortality; women experience more psychological symptoms and

more personality dysfunction than do men (Kay & Bergmann, 1980).

Factors such as adverse social conditions, loneliness, widowhood, family problems and previous psychiatric problems can all contribute to the disguise or exacerbation of the symptomatology of anxiety disorders in the elderly. A major complication in the diagnosis is that many physical illnesses present the same physical symptomatology, e.g. cold sweats, and heart palpitations, that are symptomatic of anxiety disorders. Recent studies suggest that the elderly, more than any other age group are likely to take anxiolytic medications (Bliwise et al., 1987).

The Chronically Mentally Ill

Approximately two million people over the age of 65 fall into the broad category of the chronically mentally ill (Kramer, 1983). The chronically mentally ill is a non-diagnostic term used herein to describe individuals who are, or have been, or might have been, chronically hospitalized at a psychiatric facility if not for the policies of deinstitutionalization of the last two decades. The concept of chronic mental illness implies dysfunction in some area of living (social, work or self care) in addition to some psychiatric disorder (usually schizophrenia) (Perse et al., 1986). It is important to note that there is no clear

definition of "elderly" when one considers the chronically mentally ill.

Often the chronically mentally ill are seen as being in an arrested or delayed developmental phase in relationship to accomplishments of major life tasks expected of most members of society. That includes the development of family and/or social support systems, work roles and a work identity, sexual identity, and the development of one's self as a worthwhile contributing member of society, which may be absent or severely distorted in this population (Quam, 1986).

Practitioners are often confused about how to treat the chronically mentally ill as they enter into old age. While acute symptoms may decrease in old age, developmental issues throughout the life cycle must be acknowledged as well as the need to reconcile one's self to one's history and development. Programs can be designed that help some chronically mentally ill adults to focus on their potential for growth and change in the life cycle (Quam, 1986). Chronically mentally ill adults not only must deal with typical life transitions, but also numerous transitions associated with psychiatric treatment, including admission and discharge from treatment facilities, change in medications, change in treatment philosophy, and change in treatment personnel. Many chronically mentally ill adults who have reached their 50's are either prematurely placed in nursing homes or denied access to community-based programs designed for younger

clients for whom the perception of treatment outcome is better (Quam, 1986).

During 1986-1987 the National Institute of Mental Health-Community Support Programs (CSP) funded 16 programs nationally which were targeted especially for the aging chronically mentally ill adult. Critical components of this program included:

1. Extensive outreach with assessment and treatment conducted at the client's home and other community sites.
2. Greater coordination and highly linked services for the chronically mentally ill elder.
3. Modification of existing mental health programs to accommodate the special needs of the aging population.
4. Efforts to enhance clients' social support networks.
5. Selfhelp programs.
6. Training of peer counselors and other persons who work with chronically mentally ill elderly as board and care managers, and meal on wheels program staff.

It is essential that such programs adapt to the special biopsychosocial character of older persons including their physical health, neuropsychological function, level of disability, personal and social losses, and personal

experiences. Butler and Lewis (1982) present a number of characteristics of old age around which more realistic treatment strategies for the chronically mentally ill aged can also be devised. This relates to the elder's need to leave a legacy, share accumulated knowledge, have increased emotional attachments to familiar objects, recognize their sense of living in the moment and recognize their need for a sense of fulfillment. Their notions of life review and reminiscence groups, movement therapy, the importance of music, art, and cooking groups, men's and women's groups, and opportunities to reframe their life experiences are examples of specific program components.

In reviewing the literature, one must also look beyond diagnostic categories to considerations about the treatment of special populations. Given the Agency's special interest and roots within the Jewish community, emigres from the former Soviet Union and Holocaust survivors are of particular interest. While nationally these represent small cohorts, in this community they are both a concern and a priority.

SPECIAL POPULATIONS

Emigres from the former Soviet Union

There is growing concern over the hardships many senior emigres are facing as they cope with adjustment and acculturation to their new environment and the difficulty this population exhibits accessing community services for

assistance. Currently, due to funding limitations and government restriction, the focus of attention and financial resources has been on the workbound adult, leaving this older segment of the emigre community ignored for the most part. This population is struggling with the losses associated with the normal aging process as well as those introduced by the experience of transmigration (Althausen, 1991).

As the number of individuals over the age of 55 who emigrate to the United States increases and as the current emigre population ages, this population becomes a priority for the Jewish community. In 1991, approximately 37,000 individuals (of whom 27,000 were Jewish) immigrated to the United States from the (former) Soviet Union; 19.4% were over the age of 62 (NYANA, 1991, data through October, 1991).

The age of 55⁴, rather than 65 is used to define "aging" in this special population for two reasons:

1. The life expectancy in the (former) Soviet Union is ten years less than in the United States;
2. In the (former) Soviet Union, women were eligible for a pension at age 55; men at 60.

⁴ Precedent for using other than age 65 to define the aged has been established by the Administration on Aging (age 60), and more specifically in work with other special populations, e.g. PWAs (age 50) and the OMR/DD population (age 50).

The population over the age of 55 faces the greatest difficulty in adjusting to life in the United States. Many cope with the emotional impact of changes in their lives by becoming withdrawn and isolated. This tendency to limit one's world not only deprives the individual of access to assistance, but also fosters an escalating sense of despair, which can result in severe depression, family conflict, alcoholism and greater physical deterioration. Further, and even more alarming, is the fact that the suicide rate is quite high among first year Soviet emigres (Katsnelson, 1991).

Several key factors effect the emigres' pattern of withdrawal:

- ° The language barrier;
- ° The anxiety and depression caused by the immigration experience;
- ° Greater emotional investment in the culture and the society of the "old country" and, correspondingly, less receptivity to the American culture;
- ° Lack of connection with mainstream community institutions;
- ° Limited physical mobility and poor physical health;
- ° Low priority within resettlement service systems, as providers try to attend to the needs of employable younger adults, children, parents of

young children, adolescents, and refugees with acute medical and psychological problems.

In addition, many older emigres have come to the United States in order to remain close to their families. Yet, realities and priorities of resettlement for the workbound adult often leaves little time to be with an older parent, adding to the losses incurred by the Soviet emigre. Further, as retirement age (and life expectancy) in the (former) Soviet Union is lower than the United States, it is difficult for many emigres over the age 55 to accept the loss of government financial support until age 65. The mature adult emigre who left the (former) USSR as a pensioner, must often struggle with a changed role and loss of status as they need to enter the job market, competing with younger adults, or to accept public assistance benefits.

For many senior emigres, the significant emotional investment in their former society, despite issues of anti-Semitism and difficult life circumstances, adds to the difficulty of adjustment to their new environment. Loss of self-esteem, status, identity, friends, security, confidence, culture, etc. can be emotionally overwhelming. "Transmigration, like all catastrophes, produces new traumatic world images and seems to demand the sudden assumption of new and often transitory identities" (Erikson, 1964).

The traditional value of the somatic complaint as a latent request to be taken care of is well known. The elderly

Soviet immigrant is not unique in using this defense mechanism (Althausen, 1991). Soviet emigres are especially apt to somaticize because of their psychosocial and cultural conditioning. In the "old country" emotional issues were too personal to be shared, if at all, with anyone outside of the immediate family. The medical model was present and prevalent in the (former) Soviet Union; social work treatment and counseling were unknown (Althausen, 1991).

Consequently, somatic complaints may be the only legitimate way for Soviet older adults to express their emotional pain. It becomes incumbent on service providers to be ethnically competent, i.e. having "the ability to conduct one's professional work in a way that is congruent with the behavior and expectations that members of distinctive cultures recognize as appropriate among themselves" (Green, 1982).

The gap between the type of care Soviet-born elders are willing to use and the services available to them through aging and Jewish communal networks is significant. There is a recognition that existing services may have to be modified if they are to be attractive to the Soviet emigre. Consultation with emigre health professionals and with clients would be a crucial step in improving the process (Wartenberg et al., 1991).

Holocaust Survivors

Today, 40 years later, these survivors are in their 60's, 70's and older. Physical deterioration and illness have special meaning for survivors. During the Holocaust, the sick and infirm were murdered by the Nazis along with the young and the very old. Thus, sickness and old age may be associated with a certain and violent death, causing the survivors to fear and to have exaggerated reactions to the loss of physical functioning. Although the loss of bodily functions may be humiliating and shameful to the aged in general, such losses represent special danger to survivors who may re-experience the humiliating degradation of feelings of helplessness suffered under the Nazis (Cohen, 1991).

When one's long-term memories become stronger and one's short-term memories become weaker (as is often the experience of the aged given benign senescent memory loss and organic impairments), repressed experiences from the past may be reactivated in extremely frightening and vivid imagery. Furthermore, during retirement, thoughts from the past may be reinforced by current losses thus reactivating the "unfinished business of mourning" among Holocaust survivors (Cohen, 1991). It has been noted that Holocaust survivors in residential settings in Europe, Israel and North America are suffering involuntional reactions following what appeared to be normal, productive mid-life periods.

Aging, then, is an especially difficult time for survivors. One would hope that they would/could turn to their children for support. Yet some children view their parents as immortal and invulnerable as the result of surviving the Holocaust. These children may have special difficulties in facing a parent's need for help and may need help themselves in changing their images of their parents (Kahana, 1981). Children may be unable to respond adequately to their aged parent's needs because of cumulative feelings of anger over the many stressors and enormous responsibility of being the child of a survivor.

Mental health professionals who work with aging survivors need to direct attention to the children as well in order to enlist their support in assisting parents. Most survivors have not sought help. Focusing on aging survivors only as damaged individuals further adds to their sense of humiliation and shame. It is important that providers of mental health services recognize their capacity for strength juxtaposed to their need to cope with the additional impact of aging (Cohen, 1991).

Substance Abuse

Substance dependency and abuse are typically considered problems of young adults. However, there is a growing awareness that drugs and alcohol problems are experienced by

significant proportions of elderly adults (Bliwise et al., 1987). The prevalence rate of heavy alcohol use among the elderly ranges from 3% to 9% with a median prevalence of 6% in a series of studies reviewed by Bliwise (et al., 1987).

However, it is recognized that this may be underreported because diagnostic criteria used are based on norms drawn from younger patients. Current diagnostic criteria for alcohol abuse are based on frequency and amount of alcohol consumed, physical impairments associated with alcohol use and impaired performance in major social roles. Age-related physiological and social changes, however, may reduce the applicability of these criteria to alcohol-related problems in late life and may make diagnosis much more difficult.

Inasmuch as alcoholism is not as visible in older adults as it is in their younger counterparts as they are less likely to be identified through their jobs, driving while under the influence, etc., they tend to be more isolated, and often remain "hidden." Unfortunately, physicians do not routinely assess for signs of alcoholism when they examine older adults (Widner & Zeichner, 1991). Hence identification often occurs in the emergency room or inpatient facilities following a serious fall and fracture.

Within the group of older adult alcohol abusers are two sub-groups:

- ° The two-thirds who are alcohol abusers of longstanding.

- ° The one-third who are late-life alcohol abusers, presumably in response to the stresses of late life (Finney & Moos, 1984).

Conjugal bereavement, job loss and physical illness are more often implicated in the hospitalization of late-onset alcoholics compared to the elderly who began drinking earlier in their life (Wattis, 1981; Hubbard et al., 1979).

In treatment programs designed especially for elderly alcohol abusers, it has been found that individuals tend to remain in treatment longer and are more likely to complete treatment than those older adults who are treated in groups for individuals of all ages (Kofoed et al., 1987). Older alcoholics differ from younger patients in their current psychological status and respond well to sociotherapeutic intervention. However, special skills are required to effectively lead groups with older alcohol abusers. Kofoed (et al., 1987) suggest that socialization in peer groups is an effective and inexpensive approach to the treatment of the older alcoholic who is highly compliant with such a regimen. Further, counselors who thrive on a vigorously active treatment role may not work as well at the slower and gentler pace preferred by the older alcoholic (Kofoed et al., 1987).

Drug misuse and abuse literatures is broadly divided into two categories: that relating to legal drugs and that concerned with illicit drug patterns. The overwhelming pattern of drug misuse in the elderly population concerns itself with the inappropriate use of legal drugs. Not surprisingly, there is a dearth of information regarding the prevalence and nature of illegal drug use (Barone & Holland, 1987).

Whittington and Peterson (1979) suggest the lack of data regarding the use of illegal chemical substances necessitates limitation of discussion to opiate use. Incidence data for all patients admitted to the U.S. Public Health Service Hospital in Lexington, Kentucky (1963) indicated that less than 4% of the population were 60 years of age or older. Further, the ECA study identifies that drug abuse among men and women over the age of 65 is almost nonexistent, that is 0.2% in St. Louis and 0.0% at the other sites (Myers et al., 1984b). Similarly, data from the Methadone Maintenance program at Roosevelt Hospital, New York City, shows that only 0.5% of the 34,000 methadone clients in New York City were over 60 years of age.

Yet, Pottieger and Inciardi (1981), indicated that the elderly do, in fact, use drugs recreationally for the enhancement of pleasure. They suggest that drug use, street life and street crime are not strictly in the purview of the

young; 10% of the street population using drugs are over the age of 50.

Whittington and Peterson (1979) also suggest that although patterns of illicit use are low, these and other figures are an underrepresentation of incidence. In this context, it is hypothesized that older addicts camouflage their habits through a variety of sources to avoid legal harassment and scrutiny. This includes relying on the neighborhood pusher, switching from a more expensive and scarce drug such as heroin to a more accessible hydromorphone (dilaudid) and modifying patterns of use if necessary. Under-identification may also be a function of difficulty in detection given the multiple, prescribed legitimate drugs, compounded by the reluctance on the part of the family, friends and health care providers to make appropriate referrals if drug abuse is suspected (Atkinson, 1984).

Inclusion of an assessment of both alcohol and drug dependence in the differential diagnosis of the elderly becomes a critical part of the assessment process within both the health and mental health sectors. There is an unfortunate lack of cross knowledge and training between these systems of care (Speer et al., 1991a).

Caregivers

In assessing the needs of caregivers as a special group, one needs to include caregivers who are the parents of the chronically mentally ill, developmentally disabled or other functionally dependent adult children as well as caregivers for impaired adults who are either spouses or parents.

The fact that family members are the major elements of the long-term delivery system for impaired adults has evolved from insight to accepted fact (Gwyther & George, 1986). As a result of growing concerns about widespread reliance on institutions should family caregiving networks breakdown, attention has turned to caregiver burden, stress and strain as issues relevant to both practice and policy (Miller, 1989).

Caregiving has become such a ubiquitous term that its meaning has always been taken for granted; yet definition and boundaries are not always clear. The provision of assistance and support by one family member to another is a regular and usual part of family life and interaction and as such is a normative activity (Brody, 1985). Caregiving to someone with a chronic illness and/or disability, represents something that, in principle, is not very different from traditional assistance with tasks and activities. The difference, however, is that caregiving in such situations goes beyond what can be considered normative. The provision of care to a family member who has a chronic disease involves a significant expenditure of time and energy over a potentially long period

of time and involves tasks that may be unpleasant and uncomfortable. It is likely to be non-symmetrical and is often unanticipated (Biegel et al., 1991).

Concerns about the strains of caregiving were first raised by the health professionals as the impact of the demands on family members typically emerged in the health domain. The powerful themes of emotional distress and physical exhaustion which plagued caregivers sensitized professionals to the costs of caregiving (Biegel et al., 1991). Thus, burden has become a commonly recognized phenomena. Its impact in the context of **Alzheimer's disease** is recognized as extraordinary as it is an illness that places unrelenting and progressive demands for care on the caregiver as a consequence of the behavioral and cognitive deficits which restrict the ability of the impaired elder to perform activities of daily living (Zarit, Reever & Bach-Peterson, 1980).

Families of dementia patients are noted to be the hidden victims of the disease (Zarit & Zarit, 1985). They must watch their loved ones deteriorate while continuing to care for them, to prevent them from wandering or forgetting to turn off the stove. The mutual companionship between the patient and the family disappears as the afflicted person becomes more confused and dependent (Sistler, 1989). Studies of the impact of caregiving on physical and mental health note, for example:

1. An increased presence of self reported and diagnosed health problems in caregivers (Haley et al., 1987).
2. Increased utilization of medication among caregivers (Pruchno & Potashnik, 1989; Haley et al., 1987; George & Gwyther, 1986).
3. Caregivers, both male and female, consistently score as more depressed than a matched community (general population) sample (Pruchno & Potashnik, 1989).
4. The existence of depression and depressive symptomology, Cohen and Eisdorfer (1988) studied depression in a sample of caregivers living with the patient. A total of 12 (55%) met DSM-III criteria for unipolar depression ($n = 5$) or adjustment disorder with depressive symptoms ($n = 7$). None of those living away from the patient were clinically depressed. None of the caregivers were receiving treatment for their depression.
5. Mental health problems as measured by the Geriatric Depression Scale and MMPI-hypochondriasis scale were experienced by slightly more than one-half of current caregivers (that is where the patient is in residence with the caregiver). In a study by Lichtenberg and Barth (1989) this proportion increased to two-thirds during the

period following nursing home placement and dropped to one-third, six months post placement.

6. George and Gwyther (1986) and Pruchno and Potashnik (1989) provide greater specificity, with regard to stress-related mental health symptoms, using population norms as a control group. Pruchno and Potashnik report that across age and gender, caregivers experience higher rates of inertia and heart palpitations than did the general population. Male and female caregivers age 65 and over report more insomnia than did the general population. With the exception of those men age 55 to 64, all caregivers reported perspiring, headaches and bad dreams more often than controls. Comparison of male and female caregivers indicated that women have more headaches ($p < 0.01$), nervousness ($p < 0.01$), dizziness ($p < 0.05$), heart palpitations ($p < 0.01$), and sleep problems ($p < 0.05$).

7. Chenoweth and Spencer (1986) report that 20% of caregivers indicated their greatest problem is confinement to home, and isolation from friends and outside activity. For 60% of their sample, their relative's illness is noted to have effected their relationship with others, i.e. friends no longer visit, and jobs, volunteer work and leisure activities were given up.

Program planners are encouraged to develop services which are preventive and responsive to the various dimensions of caregiver burden. In the context of psychosocial interventions, Borden (1991) indicates the need to assess the objective phenomena, that is, the severity of the illness as well as the caregiver's subjective perception of the illness characteristics, appraisal of the social relationships and reliance on coping as a strategy. Any assessment should specify conditions under which the caregiver experiences strain and should determine whether differences are located in the appraisal process, such as when the caregiver interprets dementia-related behavior disturbances as willful, intentional acts or in the coping process such as when the caregiver fails to develop adequate problem-solving skills. Findings suggest that treatment efforts should help caregivers decrease distress in the appraisal of the illness characteristics, facilitate development of adaptive coping strategies and promote the use of social networks and efforts to mobilize sources of emotional support (Borden, 1991). Specifically, programs should include:

- ° Recognition, assessment and treatment of the caregiver's depressive symptomatology.
- ° Recognition of the continuation of the patient/caregiver dyad following nursing home placement.

- ° Assessment and treatment of the caregiver/patient dyad by the care team.
- ° Educational programs and peer support programs that stress pragmatic methods of coping with asocial and difficult behaviors emphasizing that these are not means of getting back at the caregiver.
- ° Interventions to increase informal supports with the family network beyond the primary caregiver (Weiner, 1990).

Unfortunately, there is a lack of knowledge regarding caregiving among special populations (for example, the minority elderly, low income elderly, and elderly living alone) and the appropriate interventions and targeting of interventions for these groups (Brody, 1990). Gurland and Cantor are currently engaged in research efforts in this area.

Caregiving for the Chronically Mentally Ill

Among the problematic aspects of family caregiving, none presents greater difficulties than caring for a psychiatrically ill family member. Particularly where the ill family member is an adult offspring, the role and burden involved in caregiving may be compounded by feelings of embarrassment and resentment regarding the often intrusive and disruptive nature of the adult child's continuing impact on

the larger family system. There has been very little research pertaining to the attitudes and beliefs that families have about their mentally ill family members (Biegel et al., 1991). Cohler et al. (1991) indicate that among late-middle aged mothers and fathers of a group of chronically ill, primarily schizophrenic young adults (generally in their 30's) who reside with their parents:

- ° 94% reported worrying about their child's future.
- ° 94% expressed concern about continuing financial dependency.
- ° 85% reported feelings of helplessness.
- ° More than 75% yearn for the child to return to his/her old self.
- ° 70% expressed concern that their offspring was too dependent.
- ° The child's age (not the age of the parent) was related to perception of burden.

Problems which elderly parents of an older chronically, mentally ill offspring confront are often the result of role exits and losses such as retirement, grandparenthood and the death of loved ones. The life review process may reactivate past parental wishes for what may have been for both the offspring and the parents and hence caregivers may require professional mental health supports.

The older adult's social and family support network may also become more constricted with age. Typically, the mother

becomes the sole caregiver for the chronically psychiatrically ill adult child. Fears of how the child will survive after death are a source of profound strain. Particularly for parents of schizophrenic adults and those who are developmentally disabled, there is a feeling of lack of community support, social isolation and increased difficulty to cope as the child ages.

If the family is to rely upon home care with the parent(s) aging, it is noted that there are special requirements which must be met including:

1. Specially trained staff;
2. The provision of structured training and problem solving methods;
3. The provision of information about the illness and its course;
4. Readily available (24 hours) assistance in the home;
5. The availability of hospitalization if needed;
6. Frequent monitoring and adjustment of medications.

Family home care, where comprehensiveness and respite services are not provided, is likely to result in elevated burden and significant interference with family function (Grad & Sainsbury, 1968). Even for those family members whose psychiatrically ill adult children are in residential settings, there is a need for information about the illness, information about financial planning, assessment of the family

unit with regard to the impact of strain on the caregiver and the potential for participation in peer support groups.

Developmental Disabilities

The 1990 population census has revealed that there are approximately 248 million Americans; 17% of whom are 60+. It is roughly estimated that .4% of older adults have a developmental disability. Although no definitive studies have been undertaken, current population estimates suggest that there are between 200,000 and 500,000 older persons with a developmental disability in the United States.

Presently, planning for age-related services for older persons with a developmental disability has become more coincident with the eligibility age of The Older American's Act (i.e. age 60) (New York State Office of Mental Retardation and Developmental Disabilities, 1991).

Most research data in the area of aging and developmental disabilities is limited to studies of mental retardation. In terms of decline associated with aging, differences are generally a function of the level of mental retardation and whether the retardation is a result of genetically or environmentally delayed development or organicity. It is suggested that persons with mild-moderate impairments evidence more marked, albeit normative decline, whereas individuals

with severe and profound impairment experience minimal decline.

Gross motor and overall independent functioning abilities appear to decline in the mid-50's. ADLs and cognitive skills, however, decline typically in the mid-70's (New York State Office of Mental Retardation and Developmental Disabilities, 1991).

Historically, persons with severe developmental disabilities had been considered to have relatively short life expectancies, would have spent most or all of their lives in public institutions and thus not become a subpopulation of concern within the aging sector. However, with deinstitutionalization, increased longevity and increased emphasis on community residence, there is a greater awareness of the need to understand the linkages between systems of care for the developmentally disabled, the aged and mental health supports for the caregiver.

Elder Abuse

Each year, more than one million older Americans are believed to suffer abuse or neglect (U.S. House Select Committee on Aging, 1990). Whether physical, emotional, financial, sexual or in/unintentional neglect, elder abuse involves the individual and his/her family system.

Personal characteristics that contribute to abuse include physical or mental impairment that results in care dependency and isolation. Most abuse perpetrators are family members, either adult children or spouses (Pillemer & Findelhor, 1988). Many provide considerable care to their victims (Anetzberger, 1987), creating a situation where victims are afraid to discuss the abuse out of shame or fear of nursing home placement (Anetzberger, 1990).

Although elderly victims of maltreatment must be the focus of immediate attention, an evolved system of protection needs to recognize that elder abuse is a family problem and the intervention should include all effected family members (Anetzberger, 1990).

AIDS

While AIDS is generally perceived of as a disease of young adults, AIDS does effect the elderly either directly (10% of diagnosed cases are in persons over age 50), (New York City Division of AIDS Services, 1991) or indirectly, as primary or secondary caregivers to children, grandchildren, friends or neighbors with AIDS (Bressler, 1990).

In her introduction to AIDS in an Aging Society, Riley (1989) explains why it is so important to become involved in AIDS prevention efforts among older adults:

"The large and rapidly growing number of people in the middle-aged and older segment of the United States population may well constitute the last major frontier for AIDS prevention. This presents an early opportunity to begin prevention efforts now, to forestall any possibility that the epidemic may become strongly entrenched among the more than 60 million people aged 50+. Here is an opportunity to learn from previous failures with populations first afflicted with AIDS: homosexual and bisexual males, intravenous drug abusers, and their sexual partners, any one of whom may unwittingly already be infected."

A significant number of older caregivers are spouses or sexual partners of persons with AIDS. For them, the stress of caring for a terminally ill person is exacerbated by the stigma of AIDS and by the fear or knowledge that they too are HIV infected.

Professionals who work with the elderly can address the direct or indirect victims of this epidemic by providing education, treatment and support (Bressler, 1990).

EXISTING PROGRAMS

"Practice innovation implies a new way of looking at an old problem" Gwyther, 1991.

Planning and practice efforts in aging are guided by the following objectives:

1. To provide older adults and their families with effective services that are efficiently delivered.
2. To allow older consumers as much discretion as possible in the services they use and enhance to the fullest extent possible their participation and planning.

3. To encourage and support informal systems and volunteers.

4. To enhance the coping resources of older consumers and their caregivers (Harel et al., 1983; Dunlop, 1980).

These objectives also imply knowledge about stressors and coping resources of informal caregivers, information on service objectives, services used and service impact from the perspective of the consumer as well as cost benefit data from the perspective of service planners and providers.

The diverse group of professionals and para-professionals who administer mental health services to the elderly participate in a fragmented system with limited commonality and training, philosophy, therapeutic methods and objectives. Yet a number of inspiring and innovative programs do deliver care and comprehensive services, albeit to a relatively small number of older adults. Such comprehensive geriatric care usually requires interdisciplinary collaboration. The contribution of each type of provider depends upon the diagnosis, the disease stage and severity, and the availability of patient and caregiver resources (Gottlieb, 1990).

Bachrach (1989) and Talbott (1985) identify 13 features that typically characterize programs for the chronically mentally ill and suggest their relevance to programs for the elderly:

1. Targeting of a chronic population.
2. Linkages with other resources.
3. Functional integrity (i.e. the programs provide health care, nutrition, rehabilitation, etc.).
4. An individually tailored treatment plan.
5. Cultural relevance and specificity.
6. Specially trained staff.
7. Hospital liaison.
8. Lifetime perspective.
9. Active engagement.
10. Accountability.
11. Multi-modality.
12. Survival skill training.
13. Internal evaluation.

While these program elements are noted as critical to a continuum of care, the ideal concept of the continuum of care has not yet been realized or even made feasible. In precise definition, different motivations and goals among providers may, in fact, make the ideal of a continuum of care not even attainable (Evashwick & Weiss, 1987). The concept may never have a precise definition because any continuum is local and each community must build upon its resources, environment and the corporate culture in each relevant organization. Without elaboration, Evashwick and Weiss (1987) state, "there is qualitative research that provides some evidence that

comprehensive, continuous and coordinated care does make a difference."

The continuum of mental health programs for older people is defined in a variety of ways. For example, Cohen (1982) differentiates between facility-based services (i.e. direct services and treatment, direct service to promote mental health, indirect services for promoting mental health, including, for example, consultation to senior centers and indirect services to include consultation to nursing homes) as compared to outreach-focused services which include satellite clinics, traveling teams and home-delivered services.

In contrast, Gurian (1982) notes that mental health needs and services are arrayed along a continuum ranging from "normal" functioning for a given age cohort and cultural group to psychopathology of late life. In that context, each program is structured to maintain well being or to promote a return to the pre-morbid homeostasis at any given point along the continuum. Further, each program is designed to supplement and build upon available community services. Expansion and coordination of community and institutional mental health, social and health services are seen as a way to strengthen informal supports.

Lebowitz, Light and Bailey (1987) emphasize the importance of the creation of a specialized geriatric program within the context of the community mental health center. That specialized geriatric mental health program generates

itself, a broad range of affiliated activities. The interactions are generally viewed as desirable in and of themselves and demonstrate a commitment to coordinate, collaborate and develop a team approach. Affiliations with the local area agencies on aging relate to the development of a range of indirect services including consultation, education and advocacy.

Lebowitz (1988a) indicates that current community mental health programs for the elderly provide a range of outpatient assessment, treatment and crisis intervention services with small programs moving outside the central facility to such sites as nursing homes, senior centers and special housing. He notes that the policy question is, "at what point in the continuum of community-based services for the aging and mentally ill, is it necessary to establish free standing specialized services for the elderly with mental illness?" Elsewhere, Lebowitz (1988b) suggests the level of medically oriented day care as being appropriate.

Further, the National Council of Community Mental Health Centers (1989) notes that more intensive outreach, dissemination and understanding of proven treatment approaches, collaboration with community health and social service agencies and staff education and training is requisite. Further, increased community education is required because the stigma of mental illness continues to be a major barrier to mental health service use.

Model Programs

In 1988, 23 community-based elderly service programs from across the country were identified by the National Council of Community Mental Health Centers as potential models. These 23 programs were selected from among a national survey of more than 600 members of the National Council.

Structured telephone interviews by the National Council yielded a subgroup of 10 programs whose adherence to a consistent framework of service delivery structures and principles have resulted in a relatively high rate of elderly services use. In all cases, the percentage of the agency's caseload of individuals above the age of 65 is at least above 7.8% to 9%, which was the overall National Council of Community Mental Health Centers rate of use noted between 1985 and 1988. Other distinguishing factors include:

1. Programs that are particularly designed for and are responsive to the unique needs of the elderly.
2. Professional clinical staff who are specially trained in the provision of mental health services to the elderly.
3. Aggressive outreach that engages elderly community residents in need and expanded access to the mental health system of care.
4. Strong linkages to other community agencies providing services to the elderly including the health care and social service networks.

5. Services which are evaluated and re-examined for their impact and effectiveness in order to improve overall service delivery.

The five key sources of program funding included: state and federal sources; city and county; Medicaid; other specialized sources; and Medicare. Neither client fees nor private insurance played a significant role. The "other specialized sources of funding" noted above include:

1. Local senior centers and associations which provide direct fees and inkind support.
2. Private foundations.
3. Civic organizations.
4. Revenue from consultation and training.

Within all 23 programs, an average of 9.2% of the total caseload was over the age of 60. Within those top "10 programs" the average elderly caseload was 14.4% of the agency caseload, consistent with Lebowitz's (1988a) research on the benefits of elderly services specialization. There was no relationship between the proportion of seniors residing in the catchment area and the average elderly caseload within these model programs.

Treatment and Program Approaches

° 22 of 23 (96%) of the programs provide treatment, education and support (primarily in groups) responsive to the unique needs of elderly clients, their families and other caregivers. Specific groups cited as examples include rehabilitation following a stroke; depression in older women; sexual assault; and substance abuse. In addition, educational groups provide basic information on the physical and emotional aspects of aging, sexuality and bereavement. Caregivers' support groups are provided as well as groups for higher functioning elders to enable them to cope with loss, retirement, physical disabilities, and memory enhancement.

° There is significant use of senior volunteers as peer counselors providing emotional support to the homebound as well as concrete services including shopping, transportation, and the payment of bills.

• The provision of comprehensive physical and medical examinations by the community mental health center had a significant impact on the mental health service use by the elderly. Special centers (those with the highest usage) were five times more likely to report provision of comprehensive physical and medical examinations.

° 11 of the 23 centers (48%) offer specialized residential programs including congregate care, group homes, adult foster care and respite programs.

° 10 of the 23 programs (43%) employed staff with special training in geriatric mental health. In addition to continuing education, education was also provided to non-elderly specific professional and paraprofessional staff.

° 22 of the 23 programs (96%) provided aggressive outreach which includes clinical assessment; crisis intervention; treatment and counseling; medication monitoring and case management within the individual's home, at nutrition sites, hospitals and even street corners -the point that was made is that the services are provided wherever the community needs them.

° 22 out of the 23 programs (96%) provide clinical and case management services.

° 8 of the 10 programs had transportation capacities, using volunteers to the degree possible.

This researcher wrote to each of these 23 programs requesting specific information about services, budget, staffing, etc. Nine programs responded with program brochures and descriptions consistent with the information noted above.

In several of these cases there were also follow-up telephone contacts. One program reported a significant downsizing due to financial constraints; one letter was returned with "addressee unknown." There was no response from the other twelve programs.

The "model" community-based programs also take a leadership role with other community caregiving agencies in coordinating services within an increasingly fragmented service delivery system (Bachrach, 1989). The critical importance of service coordination between the community mental health center and area agency on aging has been underscored by Lebowitz (1988a). It follows then that there is a strong commitment to promoting and participating in the community's overall aging, health and mental health service systems.

Finally, program evaluation which includes clients' satisfaction, evaluation of readmission rates to program, evaluation of admission and readmission rates to the hospital and outcomes of treatment evaluated against pre-established goals and expected outcomes are components of the model programs.

In-home and institutional respite, adult day treatment, interagency case review teams, and therapeutic foster care have been noted as additional program components in these models as well as other geriatric mental health programs

(Brewer, 1992; Keizer & Feins, 1991; Lunardini et al., 1991; National Council of Community Mental Health Centers, 1989).

RESEARCH PRIORITIES

It is clear that significant research is required to better understand the etiology, treatment and system relationships of mental health services to the elderly. Specifically, research is needed to:

- ° Understand the use (or non use) of mental health services by the elderly;
- ° Study the psychological concomitants of illness and how these effect self care and response to formal care;
- ° Study comparative effectiveness of different modalities of treatment of chronic mental disorders;
- ° Examine the effectiveness of behavioral and social interventions on the outcome of long-term illness (Institute of Medicine, 1991).
- ° Elucidate the unique aspects of the mental health provider disciplines and develop models for effective interdisciplinary collaboration (Gottlieb, 1990).

- ° Study the effects of race, gender, and social status on mental health services use by older adults;
- ° Study the role of treatment as a factor in improving social and physical function;
- ° Study the effects of earlier psychiatric intervention on reducing late life disability and health care costs;
- ° Study the provision of mental health services to the elderly institutionalized residents of nursing homes in the context of need, utility and outcome (Institute of Medicine, 1991).
- ° Study the extent to which somatic complaints may result from physical illness alone and/or in combination and interaction with depression (Waxman et al., 1985).
- ° Identify more age-appropriate depression diagnostic criteria for the elderly (Speer et al., 1991).
- ° Define appropriate-age criteria that are relevant for the delivery of aging-based mental health services.
- ° Evaluate to what extent the chronically mentally ill elderly and their families are similar to other, younger chronically mentally ill populations; evaluate to what extent the

chronically mentally ill elderly and their families are similar to other populations responding to disability conditions; assess to what extent the chronically mentally ill elderly and their families are similar to other elderly populations (Smyer & Birkel, 1991).

- ° Evaluate the quality and outcomes of mental health services delivered in home and community-based programs (Harper, 1992).

- ° Better understand the mental health needs and status of minority elderly (Institute of Medicine, 1991).

Chapter 3: Literature Review: Planning as an Organizational Need

In completing this planning process and developing a "plan to plan", the literature review of mental health and the aged must be complemented by a literature review of planning approaches and social marketing. This chapter provides that equally important background.

The host agency for this project is, as Frumkin et al., (1987) define it, a large human service organization. A primary characteristic of such organizations is that they contain two or more major functional programmatic areas. Large human service organizations encompass multiple sets of programs within a single administrative structure. Often, they suffer from an inability to plan, control their own goals, control their own borders and establish priorities (Frumkin et al., 1987).

Yet, it is planning that forces managers to anticipate change and to prepare to cope with it, including new opportunities, new markets, and a chance for growth (Boone & Kurtz, 1987). The ability to develop effective plans and the need for planning is not limited to large organizations nor to comprehensive and/or strategic planning endeavors. Although large organizations often have added resources, special talent

and time to develop detailed plans, effective planning may be even more important to smaller organizations. In many cases, smaller organizations possess limited resources and cannot afford the luxury of trial and error in program development or of failure (Boone & Kurtz, 1987). From a proprietary perspective, Boone & Kurtz (1987) define planning as a process by which management sets objectives, assesses the future and develops a course of action. Consequently, careful planning will result in the development of a blueprint describing the means by which to accomplish those objectives. Hence, planning can be viewed as an important function within human service organizations, regardless of size or complexity.

In complementary fashion, Kahn (1969) describes planning as a developmental process in which several levels of intellectual undertaking are in constant interaction. In the real world, he suggests, planning tends to begin because there is a complaint, tension, disagreement, dissatisfaction, conflict, suffering, need for choice or perhaps even a bill enacted by the legislature or some combination of the above, or perhaps even a vision, which acts as the catalyst. To talk of the goal of "meeting" human needs is, he explains, to be involved in a complex human calculus not starting with a fixed and readily formulated given.

Regardless of the specific definition, it is assumed that planning "means a deliberate intervention in some process" (Cartwright, 1977). More specifically, Gilbert and Specht

(1977) suggest that planning in response to needs can be described from two perspectives: planning as a technomethodological process and planning as a sociopolitical process. These perspectives illuminate, in fact, the range of the planner's role. They summarize four models of planning which can be conceived of along an analytic-interactional continuum.

1. The rational decision making approach conceives of the planning function as orderly, and logical, which progresses from diagnoses to action, based upon an analysis of relevant facts, theories and values. The correct (or "best") solution is attainable in this model as it is a technical dilemma solved by careful data analysis.
2. The mixed scanning approach (Etzioni, 1977) involves a combination of elements from the rationalistic approach that emphasize the analytic tasks of research combined with the consensus building notions of the incremental approach.
3. Disjointed incrementalism (Lindblom, 1977) involves choosing among a limited range of alternatives that differ in small degrees from existing policy. The

model suggests that consensus is extremely difficult to achieve and is most likely to occur in proposals for incremental change.

4. The transactive approach begins with the notion that planning is a social process with the critical element the quality of the interaction between the planner and the client.

In addition, transformational planning which creates an organizational vision, projecting far ahead and working in strategic increments to achieve that vision is suggested as a planning model (Solomon, 1992).

Certainly these models are not mutually exclusive, but rather provide the planner with parameters and options and a potential framework in which to operationalize his/her specific tasks.

These strategies represent the antithesis of Kingdon's (1984) notion of a garbage can model of planning. That is, the "garbage can" is the metaphor for how an organization makes decisions within four separate streams: problems; solutions; participants and choice opportunities. Each stream has a life of its own, largely unrelated to the others. Thus people generate and debate solutions because they have some self-interest in doing so, not because the solutions are generated in response to problems or in anticipation of an

upcoming choice point. The outcomes then are a function of the mix of garbage (problems, solutions, participants, participants' resources) in the garbage can and how it is processed.

Hornick and Borrows (1988) suggest that the goal of the planning activity derives from a conceptual need which also helps to shape that concept. While sometimes related to strategic planning, a critical first step in the development of any new service is a needs assessment, to verify that a problem exists within a client population, to an extent that warrants the proposed service. Orthner et al. (1986) also suggest that needs assessments can help to focus organizations, services and people into a cohesive unit aimed at certain objectives.

Marketing as a Planning Framework

Marketing literature is more proactive and emphasizes that an organization that doesn't plan is quite vulnerable to competitive threats. Consequently, organizations must know their strengths, and weaknesses and the likely plans of their competitors (Zuza, 1985). More specifically and with regard to this project, Evashwick (1984) indicates that the health care organization that begins to now understand and target services oriented toward the special needs of older people and

to market them effectively will be well prepared to enter the 21st century.

Yet the notion of marketing and its relationship to role and function within the human service organization is not yet well integrated into the field. Further, mental health has lagged behind in the application of techniques and strategies developed in the fields of marketing and consumer behavior. This has been due to the reluctance to openly acknowledge the business component of mental health service provision, as well as to the unique problems inherent in the problem itself, i.e. mental illness (Johnson, 1990).

In Drucker's most recent book, Managing the Nonprofit Organization: Principles and Practices, (1990) he interviews Philip Kotler with regard to "defining the market." Kotler notes that as recently as two decades ago, there was no awareness and little receptivity to the notion that nonprofits had to do strategic marketing. Marketing as a generic and universal concept had applicability to all institutions and needed to be brought into the nonprofit world more consciously.

Kotler indicates that hospitals were the first within the nonprofit sphere to take the notions of marketing seriously. Unfortunately, other nonprofit organizations confused marketing with hard selling or advertising. For Kotler, the

most concise definition of marketing is "finding needs and filling them to produce a positive value for both parties."

Marketing as an "acceptable" concept is spurred by the recognition of an increased competition that institutions face in a way they have never faced them before. Wagle et al., (1989) note that mental health service agencies, like other institutions, must also compete with one another in today's health care market. A marketing orientation can encourage new ways of thinking about program modification and diversification and consequently better fulfill this new competitive role (Wagle et al., 1989; Genkins, 1985). Marketing theory provides a way to harmonize the needs and wants of the outside world with the purposes, resources and objectives of the institution (Kotler, 1990). However, social marketing proponents caution that commercial marketing knowledge must be transferred with sensitivity to the requirements and norms of social services and that such knowledge should be exploited and acknowledged rather than ignored (Rothman, 1983).

A marketing approach is, in fact, compatible with the societal values expressed in the official statements of most human services organizations as the marketing concept is the philosophy that the consumer's interest is the starting point, if not the major focus from which all planning takes place (Fine, 1981). With an emphasis on the needs and interests of

the publics involved, such an approach increases the likelihood of a responsive service program (Lauffer, 1986).

Many human service organizations tend to begin with the assumption that products⁵ (or services) and the actions engaged in are in the best interest of the public. Human service providers further assume there is a need, even if sometimes there is no demand, simply because we are convinced "that it is good for people" (Lauffer, 1986). A marketing orientation is quite different. It begins with an examination of the needs and interests of the consumer and other key publics including resource suppliers and other service providers. In sum, a strategic marketing approach provides management with a purposeful notion of the flow of resources and products between the organization and the environment. Social program marketing is much more complex than traditional business marketing (Maypole, 1991). Lovelock and Weinberg (1984) identify the unique characteristics of public and non-profit marketing:

- ° Emphasis on services...(rather than goods).
- ° Dominance of non-financial objectives.
- ° Need to devote marketing resources to attract donations.

⁵ The product is the "tangible program," service or other activity which is developed. Many agencies produce more than a single product - each ought to be viewed individually and together conceptualized as the "product line" if human service organizations are to borrow from industrial marketing approaches (Lauffer, 1986).

- ° Need to develop marketing approaches that are responsive to the needs of multiple constituencies - not just the immediate consumers.
- ° Recognition of potential conflicts between the long-term institutional mission and short-term consumer preferences.
- ° Greater public scrutiny of organizational activities and the increased likelihood of nonmarket pressures being brought to bear on the strategy.
- ° Tensions created by board members, volunteers, managers and professionals - all pulling in different directions.

Thus, market position for a non-profit, human service organization is more than a process by which an organization chooses its consumers or other publics. It is also a process by which the organization spells out the distinctive course it chooses to play vis-a-vis those publics. The recognition that many publics have an interest in an organization's programs and purposes is what distinguishes strategic marketing from other approaches to program design, implementation and delivery (Lauffer, 1986).

The issue of who is the client and to whom the marketing approaches should be directed is an important one for a mentally impaired senior population. The literature regarding effective marketing of proprietary health care services

emphasizes the need for a clear understanding of the nature of the purchasing decision. Five categories of involvement in a service decision role are identified:

- ° The **initiator** - the person who first suggests or thinks of using a particular service.
- ° The **influencer** - the person who advises and whose views carry some influence.
- ° The **decider** - the person who ultimately determines any part of the decision - whether to use, what to use, how to use, when and where.
- ° The **buyer** - the person who makes the actual purchase.
- ° The **user** - that is who is the client (Yankey et al., 1985; Kotler, 1981).

Kotler (1990) suggests that every organization is swimming in a "sea of publics." Yet that sea, including those involved in the service decision role, becomes more crowded when addressing the needs of the elderly, most especially those with mental illness.

Strategic marketing theory also suggests that an agency must formulate an offer to put out to the group from which it wants a response. The process of getting that answer is exchange thinking. "What must I give in order to get? How can I add value to the other party in such a way that I add value to what I want?" Hence reciprocity and exchange underlie marketing thinking and theory. Perceiving the

social agency user as the consumer rather than a client opens the way to think about the exchange transaction between buyer and seller (Levy & Zaltman, 1975). Conflict arises in this exchange process if there are too many barriers to satisfaction (Stoner, 1986).

A fair market in any context is one in which people have resources they want to exchange for distinct benefits so both parties perceive a benefit from the transaction (Herron, 1977). The application of exchange theory permits clear and decisive thinking about the dependent relationship between the consumer and the social agency (Stoner, 1986). This mutually beneficial exchange of objects or services which takes place between providers and those who need objects or services provides the "social profit" for the not-for-profit organization (Kotler, 1990; Wagle et al., 1989).

The different agents that are important gatekeepers, influencers and deciders (referral groups) are market segments that must be considered in planning and communicating about services. A market segmentation strategy that only considers the needs and wants of the buyer or user may be guilty of overlooking the primary factors that cause a health care or social service agency to be selected. Therefore any study should focus on the influencer, gatekeeper and decider about a decision about service use (Wagle et al., 1989). However, in so doing, one must also be conscious that there are limitations in this consumer metaphor as the client is not

necessarily in a position of power in making service use decisions.

This planning process expands the notion of this relationship or of the actual exchange to include internal as well as external publics, i.e. including other agency staff members, Board members and volunteers in relationship to this planned division. Hence the concept and realities of both internal and external marketing are described in Chapter 7 as it impacts on the planning process.

The similarities between social planning and market planning can serve as a guide for human service organizations to develop more systematic approaches to marketing services, causes and/or ideas. The commonality of the processes may also help service organizations to overcome their traditional resistance to the role that marketing can play in the nonprofit arena (Stoner, 1986).

Specifically, market planning, which is the first step or category, resembles the scanning, research, development and needs assessment phase of social planning. Table 4 links the market planning and social planning components, identifying similarities of both order and approach (Stoner, 1986; Faherty, 1985).

Table 4
Comparison of Social Planning and Strategic Marketing Approaches

Social Planning	Strategic Marketing
1. Document Problem	1. Situational analysis
2. Identification of goals and objectives.	2. Goal assessment including direction, market niche, numbers desired and expertise required.
3. Identification of alternative strategies.	3. Strategy exploration including marketing segmentation, market target and marketing position.
4. Recognition and selection of strategy.	4. Strategy recognition - product, price, promotion, place and implementation with the commitment of time, people and resources.
5. Implementation of strategy.	5. Implementation and promotion of idea
6. Evaluation	6. Assessment

Stoner (1986) suggests that a strategic marketing approach augments social planning. In this context, social marketing is a creative approach to planning and administration which borrows its analytic tools and strategies from commercial marketing. It becomes credible in the social services arena when profit is defined by the impact of the service on the clients.

Yet recognizing the benefits of integrating a strategic marketing approach within an agency-based planning process does not provide a sufficient model for completion of the task. Pribilovics (1985) describes the strategies which had been used to market the Family Service Agency of San

Francisco. Unfortunately, it includes only a description of the end-product or outcome of that process - that is, product, place, price, promotion and people. The techniques for planning and other strategic marketing interventions are neither reported on nor are they evaluated.

Similarly Faherty's (1985) case example of " 6 P's" for a senior care corporation does not explore the pragmatic issues attendant to strategic marketing endeavors. Again, the results rather than the actual process are the essence of the report. Weiner et al. (1989) also focus on the outcome of a planning process for senior adults without detailing the difficulties or ease of implementation and recommendations for planning replication. Yet, if an organization is to follow Zuza's (1985) charge that there "must be a definite plan to plan" then a specific approach must be articulated.

In summary, while it is agreed in the literature that planning is critical for program development and that a marketing systems overlay will improve the process, there does not exist a model which has been detailed and observed for its practicality within aging-services planning. Further, marketing efforts differentiated between internal and external publics have not been explored. It is to this gap in the fields of aging and planning i.e. a description and analysis of a planning process grounded in social planning and marketing theory that this dissertation is directed.

Chapter 4: Research Methodology

This chapter will describe the needs assessment and planning strategy as originally conceptualized, the actual needs assessment and planning processes as actually implemented from both a technical and dynamic perspective, the Agency setting, sample, and use of the planner's time.

THE NEEDS ASSESSMENT

There is clear agreement that the problem or situational analysis should be seen as the first step of a series of related activities in the planning process. This analysis usually should focus on understanding the problem in the context of the environment - not on the solution (Kettner et al., 1990; Lareau, 1983; Kahn, 1969). Kahn (1969) indicates that the planning task is the formulation of concepts to guide the planning in which needs and tasks are shaped together, each effecting and modifying the other. The problem, need, concern or promise has launched the endeavor; the planner must now do some or all of the following (Hornick & Borrows, 1988; Kahn, 1969). These represent the technomethodologic approaches:

- ° Define the problem in detail, including precise estimates of numbers and of distinct individuals or social units exhibiting the problem believed to exist.
- ° "Diagnose" the causes.
- ° Seek relevant theories.
- ° Get realistic estimates of scope and scale, including rates under treatment and demand for service within a community.
- ° Consider the inter-relationships of component parts.
- ° Project relevant variables into the future.
- ° Inventory present resources including the skills of agency staff and estimate future resources.
- ° Compute present and future staffpower.
- ° Examine relevant legal rights, sanctions and precedents.
- ° Translate these needs and resources into geographic units, time units and other critical variables.
- ° Assemble interpretations placed by others on these facts and appraise such interpretations.
- ° Estimate the consequences of the interventions.

Kahn (1969) suggests that inadequate investigation of the relevant realities, and relevant social factions is utopian thinking or blind planning. In Kahn's model, the planner has

great power as it is he/she who must decide what is relevant and which aspects of reality must be understood most clearly because of their significance in the choices to be made.

Kettner et al. (1990) and Epstein and Tripodi (1977) add to Kahn's list of questions and in so doing provide the sociopolitical frame:

- ° What are the characteristics of the experiences or the conditions?
- ° What social values are threatened by its existence, i.e. how would people in the community respond to the presence of the condition if they knew it existed?
- ° How widely is the condition recognized?
- ° Who defines the condition as a problem - and its corollary who would support and who would oppose the resolution of this condition?
- ° What is the target population's characteristics?
- ° What is the community's readiness to deal with this problem?
- ° Are there ethnic and gender considerations in problem definition and program development?
- ° What are the existing programs to meet these needs as well as location of existing resources that could enhance the operation of a new program?

Once the problem is identified it can then be translated into needs and ultimately into a service plan, after consideration of the necessary resources, recruitment of clientele, assessment of training needs and coordination with other community programs (Epstein & Tripodi, 1977). Additionally, program planning and design that incorporates marketing notions will identify the desired market segment, market share niche and position in the translation of needs to service.

Yet both Siegel et al. (1984) and Lareau (1983) express dissatisfaction with regard to human service organizations' ability to determine and document that needs do exist in a population. Lareau and Heumann's (1982) study of 400 agencies concerned with planning for the aged substantiate this belief. In that study, 58% of the 252 responding agencies claimed to have used or completed a needs assessment, but in only 79 cases could the documents be located. The explanations provided by these agencies suggested that the remaining needs assessments were informal efforts that had not been documented. Of the 79 documents obtained, 43 were judged to be actual reports of needs assessment efforts and were evaluated in terms of quality. Three-quarters of these documents were viewed to be of such poor quality that they could not provide meaningful input into an agency's planning process. Lareau (1983) concluded that since there is no true theoretical foundation upon which needs assessment studies are

built, that there can be no universal agreement on its meaning. Individual practitioners are thus left with the responsibility of finding and operationalizing, usually based on experiences with academic disciplines, the needs assessment and planning models.

Siegel et al. (1984) note that, "our communities are peppered with uncoordinated and loosely integrated programs that overlap and compete for sparse resources. Without adequate assessment of human services needs, this poorly monitored and uncoordinated situation will persist and worsen."

Even the concepts of needs identification and assessment are such that there is no set of generally agreed upon steps, which when carefully followed lead to a comprehensive assessment of needs. The reality is that planners and programmers, at minimum, must decide what information will generate the most comprehensive identification and assessment of needs in a specific geographic area and what proportion of program resources should be allocated to that effort. Some of the relevant variables that merit careful consideration when planning include:

1. **Information** - what assessment data are more relevant for local programs? How easily obtained are they, what is their accuracy and usefulness?

2. **Resources availability** - from both a staff and fiscal perspective. What is the cost of collecting this data; will the benefits outweigh the cost?
3. **Is the service system new or in its early program stages?** How wide a range of services are currently available? Is there a service system organization available?
4. **What is the community's tolerance for surveys, community forums and other approaches to assessment?** (Siegel et al., 1984; Lareau, 1983).

Siegel et al. (1984) conclude that a process of convergent data analysis, that is, information gathered from a range of needs assessment methods, deployed both systematically and sequentially, will yield a reasonably accurate identification of community needs and an assessment of relative priorities. This follows Hornick & Borrows' (1988) recommendation that the systematic needs study will use data from as many sources as possible.

Consistent with the marketing approaches articulated in Chapter 3, Siegel et al. (1984) also note that beyond describing needs, assessment is also useful in identifying those factors within human services networks which may aid or impede attempts to meet needs:

- ° Current or potential resources.
- ° Political and societal value systems.
- ° New interventions.

Table 5 links the specific methodologies included in both Siegal et al. (1984) and Lareau's (1983) typology of potential needs assessment strategies. In completing the needs assessment and ultimate program plan attention must be given to an actual definition of need.

Bradshaw (1972) defines need within four contexts:

- ° **Normative** - that is consistent with existing standards or norms.
- ° **Perceived** - what people think their needs are or feel them to be.
- ° **Expressed** - does the individual actually attempt to obtain a service.
- ° **Relative** - the gap between levels of service existing in one community and those in similar communities.

TABLE 5: NEEDS ASSESSMENT METHODOLOGIES

Methods								
Conclusion Types	Survey of Potential Clients	Secondary Data Use	Key Informant	Group Focus/Field Meetings	Service Use or Request Statistics	Information Processing Functions	Time & Resources Needed	Measurement Outputs Needed
Type 1: Population description	APPLICABLE Can provide detailed information that may not be available from other sources	APPLICABLE Very useful for population description.	NOT APPLICABLE Other methods more suited to quantified description of the population.	NOT APPLICABLE	NOT APPLICABLE	Minimal if secondary data obtained. Secondary data		
Type 2: Description of problems of the target population (including social and health indicators).	APPLICABLE Can be used to produce a description of problems if proper questions are included.	LIMITED APPLICABILITY Synthetic estimation can be used to determine the types and extent of problems of the target population if the agency has the capability to carry it out. (Optimal sponsors = local, state, region planners).	SOME APPLICABILITY Experience of key informants leads to an understanding of the problems of the target population.	LIMITED APPLICABILITY Sample skewed by nature of method but crucial issues may be brought to light.	NOT APPLICABLE No new understanding of problems can be derived from review of previous solutions.	Compilation and new data.	Moderate	Moderate to high
Type 3: Description of available services	LIMITED APPLICABILITY Can be used to collect information on respondents' current or past use of services. Not suitable for comprehensive description of available services.	NOT APPLICABLE Note: service use and/or request statistics are considered separately.	LIMITED APPLICABILITY Available services may be listed but not quantified. Not efficient.	NOT APPLICABLE Inefficient, inaccurate approach to information about existing services.	APPLICABLE Summary for quantification of services.	Compilation and development of new data.	Moderate	Moderate
Type 4: Determination of unmet need	LIMITED APPLICABILITY Can provide part of raw material for supply-demand match; if questions are asked concerning needs for which no help is available, method has some applicability.	NOT GENERALLY APPLICABLE Synthetic estimation might be possible in a few agencies.	APPLICABLE Key informants will have formed judgments based on experience concerning unmet service needs.	LIMITED APPLICABILITY Crucial unmet needs may be brought to light but unsuitable for this purpose.	APPLICABLE Can provide indication of insufficient supply of services if request statistics are used. Can provide raw material for supply-demand match.	Development and integration	Moderate	Moderate
Type 5: Priority determination	SOME APPLICABILITY To be applicable questions asking the respondents' priority rankings must be asked. To be applicable questions asking the respondents' priority rankings must be asked.	NOT APPLICABLE	APPLICABLE Key informants' priority rankings are based on experience and contact with persons in the community.	LIMITED APPLICABILITY If participants are carefully chosen, group process may be useful for priority setting.	NOT APPLICABLE	Development, compilation and integration	Moderate	Moderate

Note: "Applicable" indicates that the method provides a useful approach to the outcome. "Some Applicability" indicates that the method may be useful in certain circumstances. "Limited Applicability" indicates that in certain circumstances some useful information may be generated, and "Not Generally Applicable" indicates that the method may be useful in certain rare instances.

Adapted from: Larson 1983 and Siegel et al., 1984

Marketing theory suggests that perceived, expressed and relative needs must also be viewed along a demand continuum. In that context, Kotler (1975) defines "negative demand" as a state in which all or most of the important segments of the potential market dislike the product and might conceivably pay a price to avoid it. The "no demand" level exists when all or important segments of a potential market are uninterested or indifferent to a particular object. Objects, or in this case services are familiar but perceived as having no value, or the services have value but are not available in the market or the services are innovative, unknown, and not familiar due to a lack of exposure.

The state of "latent demand" wherein a substantial number of people share a strong need for something which does not exist in the form of an actual product also needs to be considered in defining both needs and gaps in services.

The issue of negative demand, no demand and latent demand states are especially relevant for the planning of mental health services to the elderly given their systemic underutilization of services as described earlier.

THE PLANNING FRAMEWORK

The project goal is to describe a pragmatic model for aging-services planning within an agency setting, including not only a set of professional techniques, but also a description and evaluation of social and organizational processes. Using the Agency's planning endeavor for the development of mental health services to the elderly as the basis, the needs assessment and service plan development are evaluated from the following perspectives:

1. To what degree can a large human service organization conduct a planful needs assessment process with minimal resources? What would limit this process? In what ways do organizational structures and practices facilitate and/or impede the process?

2. What problems can an agency anticipate with regard to a needs assessment and planning process? (This includes staff, time, changing legislation, funding, and the need for control.) In what ways do organizational structures and practices facilitate and/or impede the process?

3. What are the intervening (positive and negative) factors that change the course of a needs assessment and planning process? How and when do those factors emerge? What solution(s) emerge? Why are some solutions preferable?

4. To what degree are the stages proposed in the needs assessment discrete? Are these seemingly replicable?

5. What are the possible ranges of staff and/or Board committee involvement in the planning process? Is the success of the planning process related to its assignment within the Agency?
6. What is the response of staff and (selected) key informants of the planning process as a way to develop and/or modify programs?
7. To what degree does the needs assessment process inform choices for program priorities and development? How are the identified needs of different constituencies reconciled in the plan development? To what degree does the planning resemble a rational approach versus Kingdon's (1984) garbage can model of planning?
8. In what form and format is the data presented both throughout the planning process and as an ultimate product? To whom and with whom is the data shared throughout the process? What is the impact of shared information?
9. What does the aging-services planner need to consider in developing services in a non-aging host setting?
10. What is the balance between marketing to external and internal publics?
11. How does the planner actually integrate conventional needs assessment strategies with marketing approaches?

The planning process designed for use within this project uses a model which is not discipline specific, but rather, uses social planning and marketing frameworks. Within that context, the ultimate goal of the planning study for the Agency is the creation of a specific service model to include service and program components, client movement between services, training and research activities and a plan for financing these efforts. Intrinsic to the effort is the recognition that collaborative efforts with other agencies make a positive contribution to coordinated, cost-effective service delivery systems. This stems from the Agency's actual belief in this principle, but also from the realities imposed by being a member agency of The Federation of Jewish Philanthropies network.

The actual planning questions to be asked include:

1. What services (described both quantitatively and qualitatively) are presently provided by the Agency to individuals aged 65 and over (that is to determine current service provision levels and the divisions via which these services are provided)? What services are provided to clients aged 50 and over to Agency clients (to determine future needs)? To what degree is the Agency unable to serve clients "simply" on the basis of their age? What services do the Agency staff (as relevant) perceive as needed and/or as priorities? What is the current Agency policy with relationship to age as

a criteria for service delivery or exclusion from services?

2. What are the normative mental health needs of individuals, consistent with the age criteria of 65?

3. What are the normative mental health needs of individuals when the age criteria are broadened (to, for example, age 55)? This is especially important for the chronically mentally ill whose physical aging is at an increased pace (Quam, 1986), as well as senior Soviet emigres whose life expectancy is 10 years less than their American counterparts.

4. What is the anticipated prevalence of mental health impairment and related patterns of service use on behalf of this population? (Included herein are social and health indicators for this population.)

5. What approaches or systems of care have been demonstrated as more, or less, effective in meeting these needs? As used here, the term "system" includes models of care within both the nonprofit and proprietary sectors as well as specific program components, e.g. adult day treatment programs, respite programs, etc.

6. What is the "state of the art" in terms of service delivery, financing and research?

7. What services are available in the catchment area for this population? What are the waiting lists for service use? What are the gaps and overlaps with regard to

service availability, professional training and research?
What are government and funding source priorities and directions for service development?

8. How does service use in the catchment area compare with national norms? What are the intrinsic barriers to service use in the catchment area?

9. What are the emerging populations in need, e.g. grandparents raising grandchildren; parents with adult children with AIDS; Soviet emigres; victims of elder abuse; substance abusers?

10. What projections can be made regarding service need and availability over the next five years?

11. How can/should a continuum of care be defined for this population, both in general and with regard to this Agency?

12. How will the implementation of all or a portion of the plan developed impact on the Agency, e.g. training, staff recruitment and retention, etc?

13. How will the priorities of service development and implementation for the Agency be consistent with that articulated by local and state governments?

14. What will the Agency determine as its service "niche" with regard to services for the elderly? How will that be translated into a geographic focus, a service focus, a continuum of care, etc.?

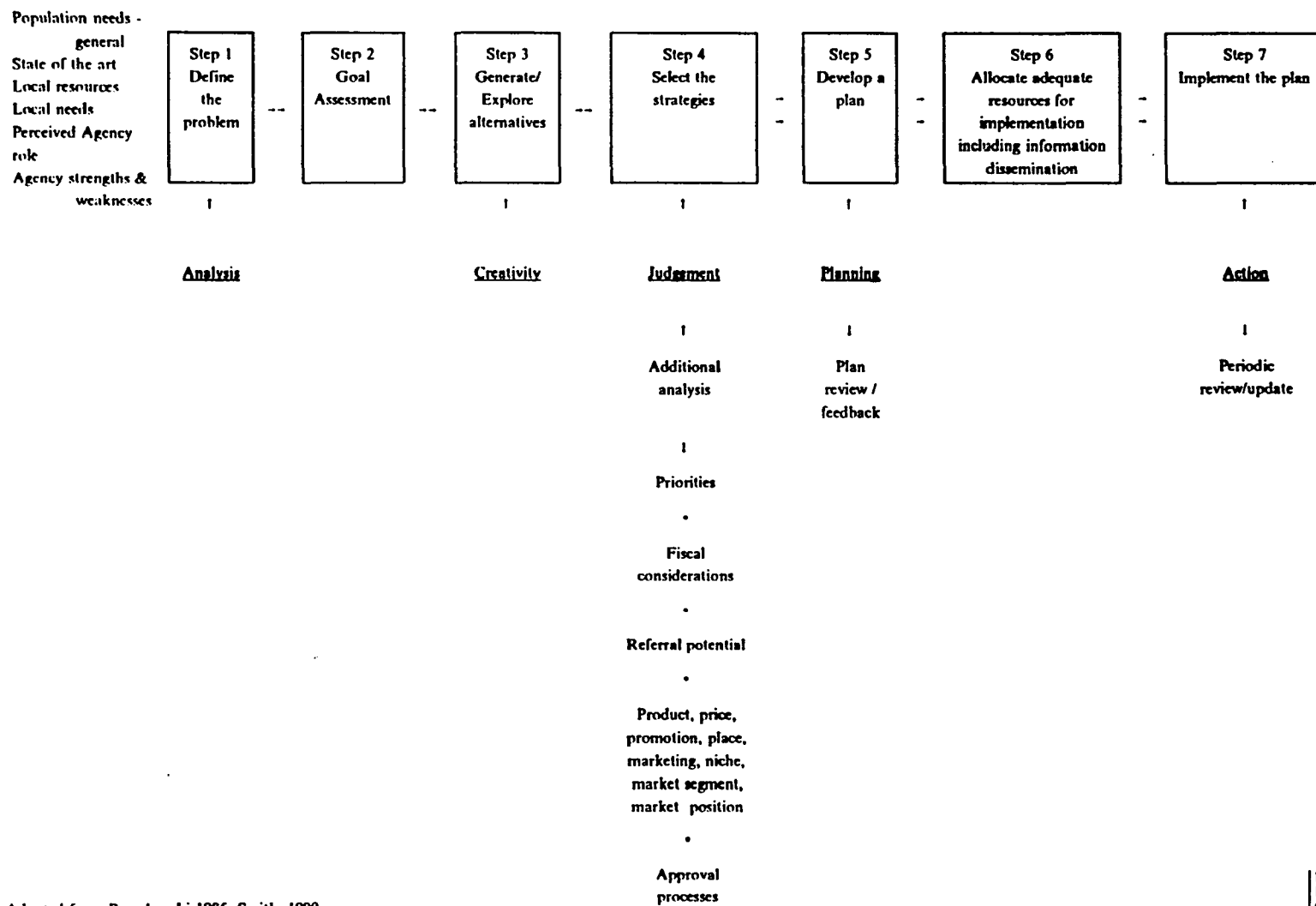
15. How will/can the timing of the needs assessment coincide with resource development? How/when can a service "wish list" be developed to stimulate foundations' interest?

In summary, the primary questions which guide this project for the Agency are: "How can or should this Agency enhance its current service provision and service development to meet the needs of senior adults? What resources will be required? What are the priorities (by service type and geographic location) for implementation? How will these programs relate to the existing Agency services structure?"

THE PROPOSED PLANNING APPROACH

The model for this needs assessment and planning study combines the work of social needs planners (e.g. Smith, 1990; Siegel et al., 1984; Lareau, 1983; Epstein & Tripodi, 1977) with the marketing approaches described in the literature review. Bandrowski's (1985) "Five-Step Thought Process" for planning has been expanded to reflect these marketing strategies and provide discrete approaches within the process (Table 6). The specific planning approaches selected reflected Lareau's (1983) scale of planning applicability, attendant cost benefits of each methodology and the time and resources required as identified by Siegel et al. (1984) and Hornick and Borrows (1988) as noted in Table 5. Specifically:

Table 6 Framework for the planning process.



Adapted from Brandowski 1985; Smith, 1990

1. A computerized literature search would be completed to determine the "state of the art" in service provision and to identify authorities within the field, and specific facilities demonstrating unique or competent approaches.⁶ This process would also include a review of existing public planning documents, program marketing materials and more traditional published papers and presentations. Information sought would include service priorities and directions, number of aged individuals in the state hospital system, percentage of psychiatric emergency room contacts (65+) etc. (Sources include, for example, the Health Systems Agency, Area Agency on Aging, Department of Mental Hygiene.)

2. Key informant interviews within the aging, health, mental health and social services systems would comprise an important component of the process. Key informants would be selected from direct service, funding and planning agencies as well as academic and research centers. A structured interview format would be designed with opportunities for open-ended comments. A member of the Agency staff would join in the key informant interview process with the researcher where that contact is politically sensitive, would benefit from such enhancement, there are special relationships, and/or the

⁶ A significant portion of this literature review is included in Chapter 2.

Agency staff member has expressed an interest in participating.

The purpose of these interviews would be to determine the perceptions of need and the context of service availability in the catchment area, to identify areas and programs with waiting lists, to identify successful models of care, and to gain insight regarding the current and future perceived marketing niche of the Agency in this realm. Also important would be the identification of future referral and funding sources and the involvement of such resources in the planning process. Finally, involvement of Agency staff at this stage would begin the process of internal marketing.

3. An analysis of the current service provision by the Agency to individuals aged 65 and above. Depending upon the data available via MIS capacities (age, gender, source of payment, diagnosis, program location, etc.) a random chart review would be considered as a means to provide relevant case material to further support expanded service provision in this realm. In addition, such data and the related chart review would provide information necessary for projections for Medicare reimbursement given the change in regulations effective July 1, 1990 which permits billing by clinical psychologists and social workers.

4. A series of nominal group meetings with, for example, adult day care center coalitions, housing directors, home care agencies, etc. to determine coalition-level perceptions of

need as well as the Agency's community profile within these sectors. Depending upon the degree of access herein, this may be augmented by a mail survey.

5. A review of how mental health services are provided to the elderly in other communities would also be completed based upon the model programs identified in the publication of the National Council of Community Mental Health Centers (1989) which identified ten model programs throughout the United States.

6. Site visits would be made to facilities or programs noted as "excellent" by either the key informants or within the literature. The purpose would be to learn more about service provision, client populations, physical environment and financing.

7. An analysis of the catchment area's current demography and projections of demography (including age, gender, ethnicity, neighborhood density, economics, residential status) would better define the target population. This would be accomplished via secondary data analysis.

Given the degree of stigma with regard to the use of mental health services for the elderly and the negative demand, no demand and latent demand status of such services, surveys or meetings with potential consumers are viewed as costly in terms of time and effort, the potential for raising of expectations, and less helpful than the approaches noted above. Therefore, neither focus groups nor public meetings

with consumers are planned. However, given the gatekeeper and influencer roles of other human service agencies, the key informant interviews and nominal group interviews are viewed as a proxy for a survey of potential clients.

Throughout the planning process, a log will be maintained by the researcher to document meetings, attendees, their consistency with the projected timeframe and needs assessment strategy, and a determination as to whether they add to the rational needs assessment process. In addition, as suggested by Yin (1989), letters, memos, calendars, agendas, minutes, reports, proposals and the formal planning report will be useful tools to support a description of the process. Using these multiple sources of information, including the researcher's notes and observations, will support accurate reporting of the chain of events (Yin, 1989), as well as answers to the questions regarding an agency's ability to plan and the organizational, social and environmental factors which impact on that agency.

The Proposed Planning Timeframe

Table 7 provides an overview of the proposed timeframe for the needs assessment and program planning processes. One component of this case study will be a comparison of actual v. proposed timing, and to what degree the steps are discrete and/or inclusive. It is therefore important to include the timeframe within the proposed methodology.

TABLE 7
PROPOSED TIMEFRAME FOR IMPLEMENTATION

	OCT*	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY
Computerized Literature Search	---->									
Orientation to Agency	----->									
Actual Review of Literature/Planning Documents	----->									
Key Informant Interviews	----->									
Structured interview	analysis									
Actual interviews	----->----->									
Observation/Visits to Exemplary Programs	----->									
Analysis of Current Service Provision/Anecdotal Needs	----->									
Nominal Group and/or Mail Surveys	Analysis									
Aging/Mental Health Providers	----->----->									
Other	----->									
Glossary Development	----->									
Demographic Analysis	----->									
Identification of Potential Funding Streams, Regulations	----->									

	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Draft plan, documents	----->														
Plan Review	----->														
Establish Advisory Group/Meet*	----->----->														
Completion of Plan	----->														
Applications for Funding	As opportunities present														
Work with other Agency divisions and agencies to explore opportunities for collaborative planning	----->														

*Decision pending

The Agency Setting

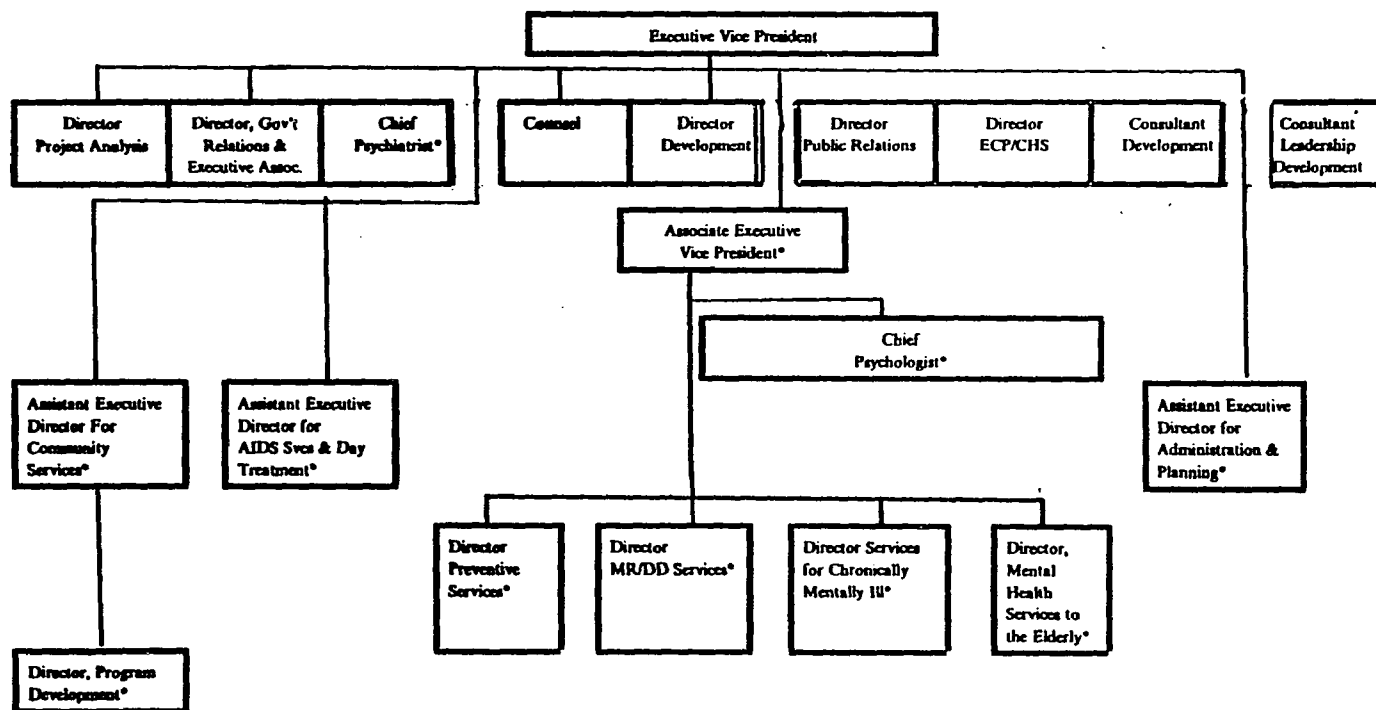
The Agency celebrated its centennial anniversary in 1992. Each year, more than 45,000 individuals, families and children are served directly in the Agency's programs and through information and referral services. The Agency has a budget in excess of \$58 million; more than 80% of this comes from government funds with the balance from philanthropic funds both for basic support and for special projects; client fees; and private insurance. By funding category, 51% of the Agency's revenues comes from its mental health programs, 25% from social services, 10% from mental retardation and developmental disability programs and 14% mixed/other. By type of program, 54% of the Agency's budget accrues from residential services and 46% from community-based outpatient services. Table 8 provides an overview of the level of care, program description, location and active clients for fiscal year 1990-91.

Table 9 provides an overview of the table of organization of the Agency as of November, 1991.

TABLE 8
OVERVIEW OF PROGRAMS - 1990/91

LEVEL OF CARE	PROGRAM DESCRIPTION	LOCATION(S)	ACTIVE CLIENTS
I. RESIDENTIAL PROGRAMS			
Residential Treatment Facility (RTF)	Legally, a psychiatric hospital for children.	3	135
Residential Treatment Center (RTC)	Legally, group and institutional care for emotionally disturbed adolescents	3	190
Intermediate Care Facilities (ICF)	Residential care for mentally retarded/developmentally disabled children, adolescents, and young adults.	3	80
Adult Residences	A community residence and supportive apartment living programs for chronically mentally ill adults. Most services are not provided on site - clients go out to day programs	2	75
II. OUTPATIENT PROGRAMS			
Outpatient Mental Health Clinic	Mental health services for a wide variety of family and individual problems, including individual, family and group treatment.	10	3500
Day Treatment	Combines mental health services with an education program for children and adolescents	5	145
Community Support Services	Outpatient services for chronically mentally ill adults, including continuing treatment (all-day services focusing on rehabilitation), a clinic, and a pre-vocational program	3	375
Preventive Services	Social services to keep families intact and prevent the need for foster care	7	900
Early Childcare Programs	Therapeutic services for emotionally disturbed pre-schoolers, including nursery programs, day care, and educational clinical services.	3	200
Other Community Based Services	A wide variety including: • Refugee services; • Special adolescent outreach programs, • Services to the homeless; • An adolescent drug treatment program, • Court and legal services; • An on-site school mental health program; • Services of the Department of Community Education, including family life education programs and religious education, • Services of the Volunteer Department.	Throughout the metropolitan area.	Data not available
ECP/CHS (Employee Counseling and Corporate Health)	The agency's profit-making arm, marketing employee assistance programs and managed care for psychiatric and substance abuse coverage.	Based at the Agency's Central Office and dealing with a nation-wide network of providers	Data not available

TABLE 9
TABLE OF ORGANIZATION
1991



* Denotes membership on Program Coordinating Committee.

The Agency's historic role in the treatment of the mental health problems of the Jewish elderly is well documented (Leichter & Mitchell, 1967). At that time, there was a discrete aging services unit that provided both clinic visits and treatment to older adults in their homes.

"...has a special unit, Services to the Aged to serve clients 60 years of age and over. The range of people served is great - from the physically, mentally and ego-intact client who has generally lived life fully but for a number of reasons (retirement, widowhood) is now struggling with problems of relationship and self-image, to the other extreme of the seriously deteriorated recluse, lying in offal, without family, frightening and alienating neighbors by stinking, breeding roaches, opening gas jets, and letting the plumbing overflow. The intensity of service varies just as widely - from a telephone contact with adult children, giving them information which may help to unsnarl the unbelievable red tape facing people in today's cities, through a varying combination of...individual, family or group counselling over a long period of time. Although the ranges persist, our staff feels we are facing an ever increasing percentage of crises involving some form of dissolution of the individual or family. It imposes great pressure on case workers." (Soyer, 1969)

Leichter and Mitchell (1967) document that:

- ° 96% of those individuals seen in the Aging Services Unit were aged 60+; whereas only 3% of those 60+ were seen in "district offices" or other Agency outpatient programs.
- ° 51% of those treated in the Aging Services Unit were aged 71+; none of the "regular clients" within the district offices were as old.

At that time, the Aging Services Unit was an integral part of the Agency's array of programs, consistent with its philosophy of treatment of individuals of all ages, within a family context. Twenty-three years ago, with the development of another agency under the Federation of Jewish Philanthropies umbrella designed to serve older adult clients exclusively, the Aging Services Unit was transferred to that new agency. One of the motivations for the development of the Agency's new division for mental health services for the aged was the fact that referrals were being made by that service entity. However, regardless of the perceived need for such services, this planning study was strategically timed to follow the retirement of the founding Executive Director of that aging-services agency.

ACTUAL PLANNING METHODOLOGY

The core components of the planning methodology basically followed in content and design the seven steps articulated on pages 114-118 and within Table 7 of this section. Specifically, and in order of accomplishment (see also Table 10 for a comparison of proposed to actual timeframe):

1. The computerized literature search was completed in October 1991. Obtaining and reviewing of the articles, and public documents to be knowledgeable about epidemiology,

symptomatology, treatment, and service delivery is indeed a discrete step, which required two months as planned.

2. Orientation to the Agency occurred first discretely and secondly as a component of information dissemination and internal marketing about the project's planning phase and ultimately during the internal data collection phase of the project.

3. Analysis of current service provision by the Agency, using MIS resources, chart reviews and manual data collation was consistent with timeframe projections.

4. Glossary development, which occurred earlier in the process than projected.

5. Identification of potential funding streams and related reimbursement and service delivery regulations; obtaining and understanding of the regulations required a full six months (versus four as planned).

6. Key informant interviews and site visits were concurrent processes as often a key informant was, in fact, directing or supervising a "model" program.

7. Four professional focus groups were possible:

- a. Adult day services providers.
- b. One geographic based Interagency Council on Aging.
- c. A human services task force of a Council of Jewish Organizations within another geographic target area.

d. Jewish Community Centers/Y's and senior citizen programs under Federation of Jewish Philanthropies umbrella throughout the metropolitan area.

These provided a complementary perspective to the key informant interviews.

In addition, through the assistance of Federation of Jewish Philanthropies, a focus group of senior emigres from the former Soviet Union provided insight into the needs of this potential client group. This group met three times and was not originally planned as a source of consumer input.

8. Review of demography, which occurred later in the process than planned as a function of the availability of census data.

In addition to the above, and unplanned were:

1. The results of a brief questionnaire administered to attendees at an Agency-sponsored professional workshop (Working with Families of the Aged). This required negotiation with the Assistant Executive Director who felt as if this would be an imposition for the attendees. The potential to view such a brief questionnaire (and other similar activities) as legitimate by a clinical agency was a difficult concept for all Agency staff to integrate.
2. A focus group of Agency staff working with senior adults and/or interested in this area of practice.
3. Access to information about telephone requests for information and referral from the Jewish Information and

Referral Service (local) and to the (national) Association of Jewish Family and Children's Agencies.

Included as potential needs assessment activities, but not actualized were:

1. Mail survey of providers.
2. Comparison of local use of mental health services to national norms as no unduplicated client counts were available.
3. Evaluation of current Agency clients aged 50+ - as state regulations have and are changing to emphasize the seriously and persistently mentally ill, current clients will in no way predict future clients who can access the mental health clinic system.

The Agency's goal (and the goal of this researcher) for submittal to Administration (i.e. the Associate Executive Vice President) of the results of the needs assessment and the related plan for program implementation was completed by the end of May (1992).

TABLE 10
COMPARISON OF PROPOSED PLANNING TIMEFRAME V. ACTUAL IMPLEMENTATION

	OCT*	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY
Computerized Literature Search	----->									
Orientation to Agency	----->									
Actual Review of Literature/Planning Documents	----->	----->								
Key Informant Interviews	----->									
Structured Interview Design		----->								
Actual Interviews	----->									
Observation/Visits to Exemplary Programs as well as Key Informant Interviews			----->				analysis			
Analysis of Current Agency Service Provision/Anecdotal Needs		----->								
Nominal Group and/or Mail Surveys Aging/Mental Health Providers Others			----->			Analysis				
Focus Groups Only										
Glossary Development						----->				
Demographic Analysis		----->								

Shaded areas indicate actual timeframes for completion, dotted arrows reflect projected timeframes.

* The planner began at the Agency on October 21, 1991.

	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL
Identification of Potential Funding Streams, Regulations	-----	----->								
Draft plan, documents						-----	----->			
Plan Review								----->		
Establish Advisory Group/Meet*		----->				----->				
Divisional Group Chairperson Identified										
Plan Finalization								----->		
Applications for Funding		As opportunities present ----->								
Work with Other Agency Divisions and Agencies to Explore Opportunities for Collaborative Planning	----->									

The use of the planner's time in a project of this magnitude, i.e. creation of a new Division within a large, complex human service organization is of interest. To analyze this, the researcher's calendar and log for the seven months of needs assessment and plan development (i.e. through submittal of the plan) were reviewed. During that timeframe there were 345 "meetings" (defined as visits, pre-scheduled data collection/chart audits, pre-scheduled conference calls, presentations, etc.) (Table 11).

The largest segment of time was spent out-of-the Agency, completing key informant interviews and site visits (22.9%), core components of the needs assessment process. However, an almost equal amount of time was devoted to Agency internal general administrative tasks (20.2%) including management and budget meetings, special task forces and committees not central (but related) to the project (e.g. committees on inservice training, domestic violence and quality assurance).

Aging-services program development included discussions and planning with regard to services, training and research opportunities and options. Both internal and external publics were involved in these activities. This required almost 12% of this planner's time.

Given this planner's interests beyond "simply" creating this Division, time was also allocated (6.4%) to responsibilities beyond the scope of the planning effort.

This included acceptance of responsibility for coordination of the Agency's managed care efforts.

TABLE 11
Overview of Time Expended, By Meeting Purpose and
Internal or External Audience
(N = 345)

Type	# Meetings	% of Overall Time	Internal/External Publics
Key Informant Interviews and Site Visits	79	22.9%	E
General Administrative	71	20.2%	I
Program, Training and Research Development	41	11.9%	I, E
Orientation to Agency	30	8.7%	I
Data Collection - Internal	27	7.8%	I
Other (Non-Mental Health and Aging Program Development Responsibilities)	22	6.4%	I, E
Regulatory Issues	21	6.1%	I
Miscellaneous	20	5.8%	I, E
Grant Applications, Foundation Identification/Outreach	17	4.9%	I, E
Focus Groups	7	2.0%	E
Interagency Coalition Meetings	5	1.4%	E
Information Dissemination	5	1.4%	I

Note: Percentages may not total 100% due to rounding of numbers.

Slightly more than one-third of the planning time was devoted to external publics including key informants and site visits, follow-up meetings regarding potential collaborative efforts, focus groups, attendance at relevant interagency meetings, advocacy efforts and foundation outreach (See Figure 1). In contrast, almost two-thirds of the planning time was devoted to internal publics including orientation to the Agency, discussion of the "planned" planning process, data collection and chart reviews and analysis of regulations, and as indicated, participation in general administrative functions and committees of the Agency (See Figure 2). The establishment of the legitimacy of the population to be served, the planner as a competent member of the management team and planning as a legitimate function were all goals of the internal marketing effort.

Proportional Expenditure of Planner's Time

Focus on External Contacts - (N=119)

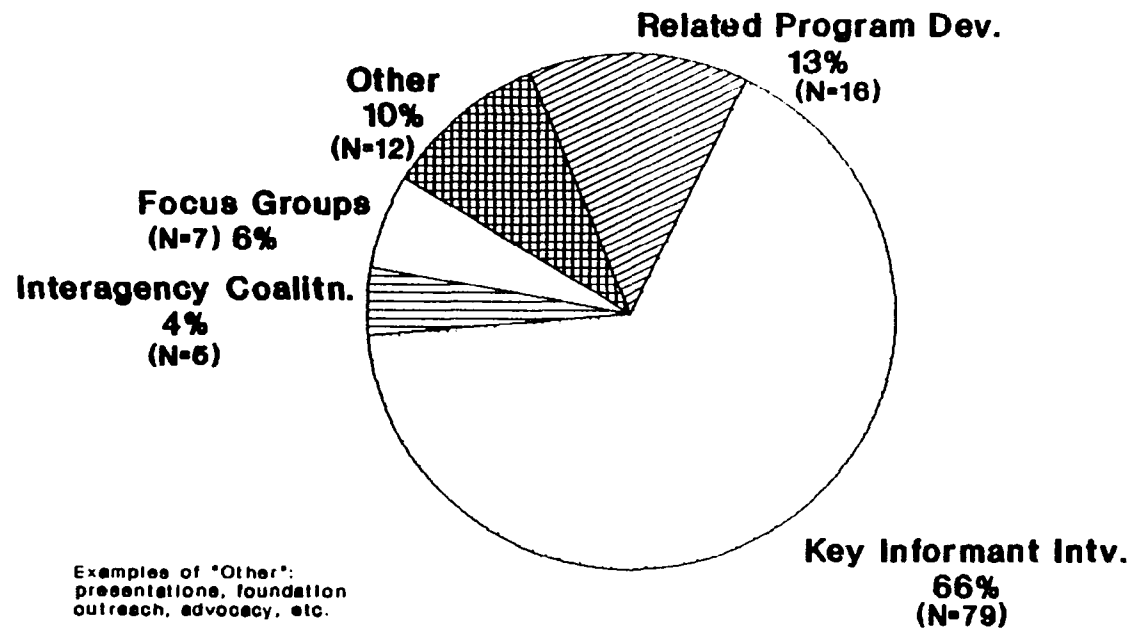


Figure 1

Proportional Expenditure-Planner's Time Internal Agency Meetings(N=226 meetings)

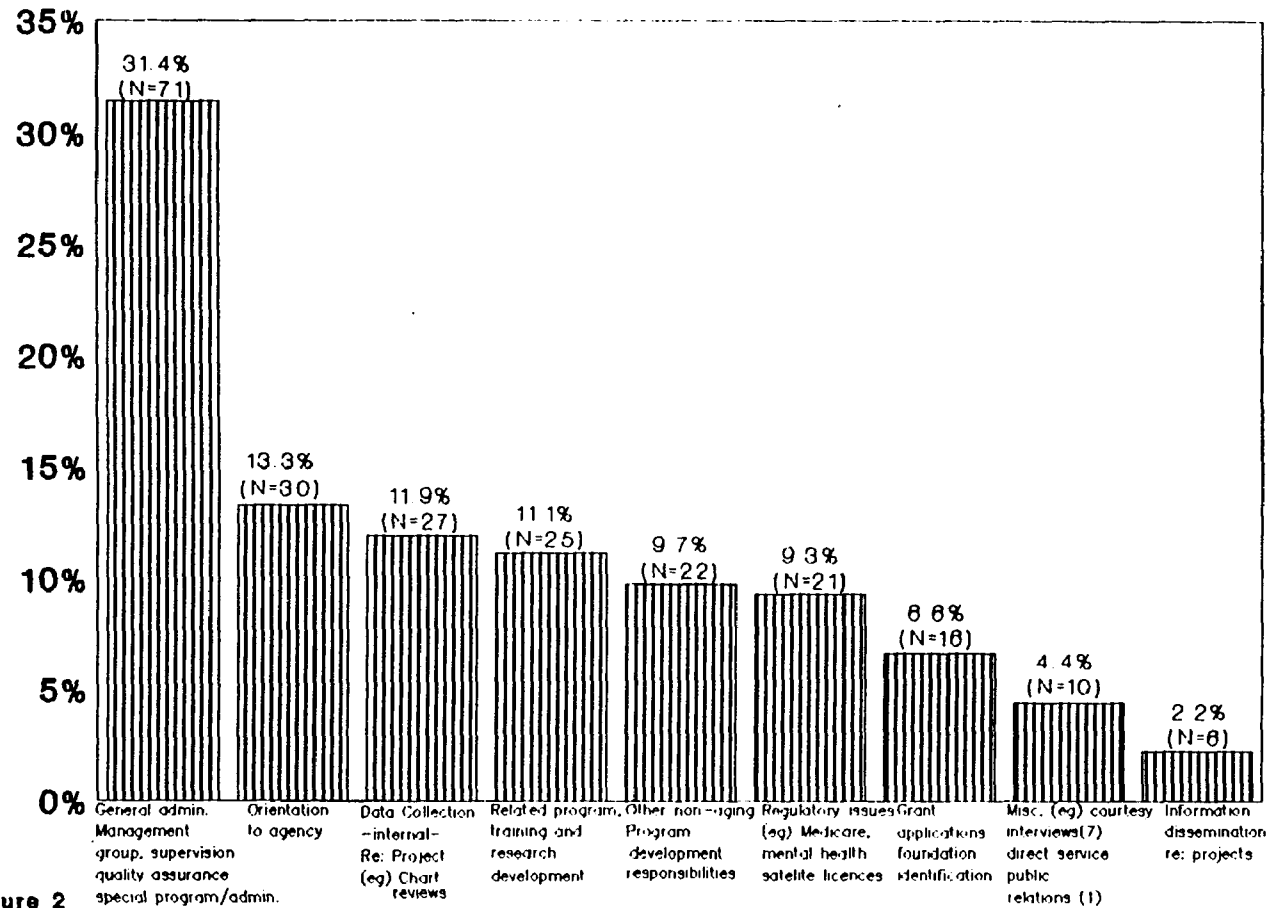


Figure 2

The Key Informant Sample

The original planning proposal identified 58 potential key informants from the mental health, health, aging, government and social service sectors. In implementing the process, 79 key informants were interviewed. Additions reflected input from key informants themselves and a detailed review of public documents.

A telephone call explaining the process was sufficient to schedule an appointment in 77 cases; two individuals (both hospital-based) required letters in advance. Three individuals (one rabbi, one senior center director and one mental health program director) did not return repeated telephone calls and hence did not participate in the process.

The major differences between the planned and actual sample of key informants were:

1. Increase in the number of mental health contacts.
2. Increase in the number of aging-services contacts.
3. Use of private practitioners (i.e. geriatric case managers) as key informants.
4. Decrease in the number of government contacts, only local government officials were involved in the planning process. It was originally anticipated that regional and state contacts would be made. However, a strong state focus on both budget and managed care suggested that this would not be viewed as their priority or even interest at this time (See Table 12).

TABLE 12
Overview of Key Informants; Planned (N = 58)
Versus Actual (N = 79)

Type of Agency Affiliations	Planned		Actual	
	#	%	#	%
Mental Health (e.g. CMHC, by licensure, psychiatric service within hospital)	3	5.2%	16	20.3%
Health (e.g. hospital, nursing home, home care agency)	16	27.6%	15	19.0%
Umbrella, membership, consortia, council	11	18.9%	13	16.5%
Aging services (e.g. senior centers)	6	10.3%	12	15.2%
Social service (e.g. family service, community center, settlement house)	5	8.6%	7	8.9%
Private Practitioner (e.g. geriatric case manager)	0	0.0%	5	6.3%
University	4	6.9%	4	5.1%
Government	9	15.5%	3	3.8%
Other (e.g. legal services, resettlement)	4	6.9%	4	5.1%

(Percentages do not total 100% due to rounding).

In anticipating the key informant interviews, it was noted that the planner would be accompanied by another Agency staff member if the contact was politically sensitive, there were special relationships and/or the Agency staff member expressed an interest in participating. During the process it also became clear that it was important for Agency staff to participate to learn about the needs of older adults and successful program responses.

Of the 79 key informant interviews/site visits, 30 (38%) were made with other staff members. These included visits with:

1. Public officials
2. Federation of Jewish Philanthropies staff
3. Programs co-located with the Agency
4. Local councils of Jewish organizations
5. Hospital staff
6. Exemplary programs

Categories 1 - 4 above relate to political agendas; 5 and 6 were for educational purposes and internal marketing of the significance of the Division, and to address (unspoken) ageist perceptions.

As indicated earlier, the Program Coordinating Committee was the Agency staff committee with responsibility for oversight of the planning process. Of the 11 members (including this planner), 10 participated in key informant interviews/site visits. In addition, each member was asked to complete a questionnaire ranking unmet mental health needs identified via the key informant interviews and their perception of the service/need as an Agency priority and/or appropriate responsibility.

Dissemination of Information

Information was disseminated and formal presentations were made to three internal publics.

The Program Coordinating Committee received, in writing:

1. The outline of the planning process (followed by an oral report on same).
2. A summary of existing mental health services in the metropolitan area for this population.
3. Summary of services provided by the Agency to individuals aged 65+.
4. The key informant questionnaire, and proposed key informants with a request for suggestions and/or additions.
5. Comparison of unmet mental health needs identified by key informants compared to their rankings. This provided the basis for decision-making with regard to Agency priorities as detailed in Chapter 5 - Findings - Unmet Mental Health Needs of Older Adults.

Agency Staff working with senior adults received, in writing:

1. The outline of the planning process.
2. A summary of existing mental health resources in the metropolitan area for this population.
3. A summary of services provided by the Agency to individuals aged 65+.
4. Glossary of aging terminology.

5. Key Informants, to date (i.e. February, 1992) with a request for additions.

A meeting with these staff included brief reports on existing Agency programs, and a discussion about unmet service and training needs.

Board of Directors received, in writing:

1. The outline of the planning process (followed by an oral report on same).
2. Summary of services provided by the Agency, to individuals aged 65+.
3. Summary of key informants.

A formal presentation of the planning process, current service provision to older adults and needs identified to date was made at the February, 1992 Board of Directors meeting.

ORGANIZATIONAL DYNAMICS OF COMPLETING THE NEEDS

ASSESSMENT AND PLANNING PROCESS

From the outset, it was clear that needs-based planning was not part of the organization's culture. Other Agency divisions had in fact emerged after programs had been developed for special populations including:

- ° Chronically mentally ill
- ° Developmentally disabled
- ° Persons with AIDS (PWA's)

In fact, the identification of unmet needs for these special populations was first articulated by either governmental agencies or Federation of Jewish Philanthropies.

The Agency's history had been to react to an already identified and even quantified need through a request for proposal or contract process. The Agency's recent reorganization included the consolidation of related programs within a Divisional unit with a Division director.

A Divisional Director whose first task was to plan and then develop programs was an anathema to executive and middle management. While it is clear to Zuza (1985), that a "plan to plan" was essential, there was no such conceptualization at the Agency. Step One was to obtain legitimacy from the Associate Executive Director for such an approach. The Agency's first (seemingly reflexive response) to this researcher's employment was a meeting to discuss implementation and funding of programs. Refocusing and reframing the first set of tasks within a planning model required listening, questioning (of Agency perceived intent) and the rapid development of a written document defining the "plan to plan."

Once this was accomplished, this notion and this planner could be acknowledged as "at least worthy of listening to."

Discussions regarding the "plan to plan" identified the need for a staff "Committee of Record" to provide input into the process and a mechanism for information flow and decision-

making. Selection of the Program Coordinating Committee as this staff body was made as it represented the key Agency program developers, managers and clinicians.

Meetings were scheduled with each committee member for an orientation to the Agency through their eyes and Division, visit to facilities (as appropriate) and for the researcher to learn of their interests and possible positive overlaps and collaboration between Divisions.

Distribution of written materials also appeared to be inconsistent with Agency culture. Whether a function of resistance (see Chapter 6), or expectations, only one PCC member responded, for example, to a written request which asked which key informants they would like to visit. Ultimately matching of key informant interviews with PCC members required telephone follow-up, appeal to professional discipline and status (e.g. psychiatrist to psychiatrist), and identification of areas of special interest (e.g. an interest in domestic violence could lead to a visit to a legal services or elder abuse agency program). Negotiation and intense follow up were key.

A second interesting dynamic related to a review of the charts of adults aged 65+. This was framed as an opportunity to project Medicare revenues - given funding constraints this was perceived as a "helping activity." Feedback on chart deficiencies was made to each clinic director individually as part of an informal debriefing.

The written report on the chart review addressed only reimbursement issues; other items remained confidential. Sacrificing an opportunity for a quality assurance activity (of appeal to an administrator) to begin to develop relationships based on trust was viewed as a worthwhile trade-off.

As was indicated, the PCC was given frequent oral and written updates on the status of the planning with requests for input. While this Agency is staffed by creative, talented clinicians and program supervisors, only after the planning report was completed, was the first suggestion for program development and exploration made.

While there was positive response to the notion of planning, (and ultimately to the plan), this activity, and the population was not a priority. The aged were a population about whom there was no expertise (except this planner) on the PCC; as a group there was anxiety about meeting the client's holistic needs, and the presumed difficulty in learning about the population. Interestingly, throughout the planning process half of the PCC members called the researcher directly with concerns about their own family and friends, who were older adults. Legitimacy through such individual contact was critical; key agency staff began to recognize the reality of mental health needs of older adults and their caregivers.

Chapter 6 describes the implications of these core dynamics as impediments to the planning with references to the literature with regard to change and resistance.

Chapter 5: Findings - Unmet Mental Health Needs of Older Adults

Given the nature of this dissertation, the findings will be reported within three chapters:

This chapter will address the findings of the needs assessment and planning process including the strategic elements of the final plan. It is included in detail for those readers whose main interest is in the development of mental health services for older adults. Chapter 6 will discuss findings related to the completion of a needs assessment and planning process within an agency setting. Chapter 7 relates these findings to a model of planning.

IDENTIFIED UNMET MENTAL HEALTH NEEDS OF THE ELDERLY

As indicated earlier, the process of convergent data analysis, that is, information gathered from a range of needs assessment methods, deployed both systematically and sequentially, is viewed as yielding a reasonably accurate identification of community needs and an assessment of relative priorities (Siegel et al., 1984).

Siegel et al. (1984) also note that beyond describing needs, an assessment process such as the one employed herein is also useful in identifying those factors within human services networks which may aid or impede attempts to meet needs including:

- ° Current or potential resources
- ° Political and societal value systems
- ° New interventions.

The following summarizes the needs identified within this metropolitan area, building upon the literature review presented in Chapter 2, and using the approaches identified within Chapter 4 (Methodology).

Review of Public Documents

Identifying which planning documents are available requires knowledge of all of the government bureaucracies and their internal planning capacities, priorities and structures. Beginning with a key informant in the public sector with an interest in being helpful makes identifying and obtaining these documents much easier. Also beginning with the government sector gives external legitimacy to the process and provides important information about the structure and scope of service providers, government supported interagency coalitions and government imposed priority populations for providers.

Although this metropolitan area has given greater attention over the last decade to the development of special mental health programs for the elderly, the lack of adequate federal and state support threatens the availability of mental health services for this population. Additionally, new State Office of Mental Health regulations targeting state-funded services to the "seriously and persistently mentally ill" exclude large numbers of those elderly persons who need mental health intervention, but lack exacting eligibility requirements. Specialized geriatric mental health services are needed to ensure that appropriate care is accessible to this population (Commission on Aging Services for the Year 2001, 1992).

Improving the mental health service system for the older adult will involve maximizing available resources, developing new programs and assuring cost effectiveness in service delivery. The (local) Department of Mental Health reports that it is increasing its efforts to expand existing services and develop new services or configurations where needed. Specific priority areas as identified by the Department in its 1992-93 Local Government Plan: Emerging Directions: A Plan for Mental Health Services are as follows:

- ° The highest priority for the Department is the development of comprehensive psychiatric emergency response systems. The City's plan calls for trained specialists in geriatric services who can

ensure the needed mobile and emergency assessment and treatment capability to serve this population.

- ° Outpatient clinic services should be included among the on-site services in senior citizen multi-service centers.

- ° Bi-lingual and cross-cultural clinic services for mentally disabled Hispanics are needed.

- ° Overcrowding in the psychiatric services inpatient system is of concern as the elderly constitute a proportionally higher percentage of that population. There is a need to develop appropriate resources and to provide incentives in reimbursement systems for the provision of alternative levels of care, when appropriate.

- ° As a function of the increasing evidence of elder abuse, the Department of Mental Health recommends the development of an elder abuse training program for mental health agencies in contract with the Department. This program would provide training to professionals and practitioners on how to identify, intervene, assist and treat victims of elder abuse.

The homebound elderly who are mentally frail are noted as a special group whose needs are not adequately addressed by the current service delivery system. Resources are inadequate to establish the number of mobile crisis teams needed to provide services to the homebound elderly and even where

mobile teams do exist, they lack the capacity to provide long-term intervention (Commission on Aging Services for the Year 2001, 1992). Approaches and the need for collaboration between departments within city government are noted as a priority by the aging and mental health sectors within government.

There is also an increasing recognition that the mental health system is serving clients who are or have multiple diagnoses and/or presenting problems. In light of this change, it is viewed as crucial to more closely link the mental health, mental retardation and alcoholism service systems. The 1992-93 Local Government Plan (DOMH, 1992) suggests broad ongoing efforts toward interactive planning between these systems.

Membership in a Service Network

Because the Agency is a constituent of The Federation of Jewish Philanthropies, the involvement of Federation as an external public was also critical. Through its divisions of geriatric and medical services, human services, refugee services and Jewish Community Centers, key informants were interviewed, the process again legitimized and the resources of the network made available. This included the convening of two focus groups and access to demographic data, service

request data, public policy and lobbying expertise and foundation liaison.

Telephone Requests for Assistance

Information about the Jewish Information and Referral Services (JIRS) was available for 1991. JIRS received 14,272 calls during that timeframe. Of these, 2741 were callers over the age of 65 (19.2%). While this number does not reflect adult children calling for information with regard to their parents or relatives, it is noteworthy that of the callers 65 and over:

- ° 6% of the calls were for individuals seeking information about counseling services.
- ° 7% were regarding "evaluation of needs" (i.e. determining the specific problem and potential resources).
- ° .5% were regarding self-help groups.
- ° 1% were regarding abuse.

Tables 13 and 14 compare all callers to JIRS with those aged 65+. Older adult callers were more often female, and concerned about an evaluation of needs, home care, and housing services than all other callers. Calls for information about counseling or mental health needs are relatively similar across all age groups.

TABLE 13
JIRS Inquiries
Comparison of Selected Demographic Variables and Reasons
For Telephone Contact, 1991
(N = 14,272 All Callers; 2,741 Callers 65+)⁷

I. Demographic Variables

<u>Gender</u>	<u>All Callers</u>	<u>Callers 65+</u>
Female	59.0% ⁸	65.0%
Male	32.0%	30.0%
Couple	2.9%	5.0%
Family	2.9%	.5%
Group/Organization	1.5%	-----
Other, Single Parent	.3%	-----

II. Referral Source

<u>Referral Source</u>	<u>All Callers</u>	<u>Callers 65+</u>
Telephone Books	36.0%	44.5%
Word of Mouth	45.0%	40.5%
Newspaper	4.5%	2.0%
Flyer	.5%	-----
Other	15.2%	12.5%

⁷ This chart is based upon 100% of the callers, aged 65+ during the month of November 1991, and 100% of "all callers" for 1991.

⁸ Percentages may not total 100% due to rounding.

TABLE 14
Selected Service Categories

<u>Category</u>	<u>All Callers</u>	<u>Callers 65+</u>
Abuse/Crime Victims	0.3%	1.0%
Camps		
(Day and Residential)	4.2%	2.0%
Counseling	7.7%	6.0%
Entitlements	0.5%	0.5%
Evaluation of Needs	1.5%	7.0%
Handicapped-Retarded	0.2%	0.0%
Home Care	4.5%	18.0%
Homeless	0.6%	1.0%
Housing	3.7%	13.5%
Immigrant Services	1.5%	0.5%
Legal Services	1.7%	2.5%
Marital Problems	0.3%	0.0%
Meals on Wheels	0.4%	2.5%
Mental Illness	0.4%	0.0%
Self-help Groups	0.2%	0.5%
Substance Abuse	0.3%	0.0%

Network membership also provided access to information about telephone calls to the National Association of Jewish Family and Children's Services Elder Support Network which indicate that "emotional disability" was an area of significant concern. That is, 14.6% of the calls related to emotional disability including depression, memory loss, Alzheimer's disease, paranoia, hysteria, extreme anger, etc. Nineteen percent of the calls were from the local area; 27% of the referrals were directed to this area. This suggests a population of older Jews whose family members are concerned and in many cases live out of town. In both cases, it supported the value of reaching out early-on in the process to external publics that have a close relationship with the Agency, an interest in its service provision capacity and reputation and under whose auspices the Agency provides service.

UNMET MENTAL HEALTH NEEDS AS IDENTIFIED VIA

KEY INFORMANT INTERVIEWS AND FOCUS GROUPS

The key informant interviews provided substantive input that basically corroborated the literature review, provided an opportunity for building bridges between agencies, allowed the Agency to go "public" with its plans to serve older adults, respond and/or hear criticisms that this population had not been served before by the Agency and respond to provider

confusion with regard to perceived overlaps/gaps in the Federation network of aging-mental health services. The value of not only the content of the dialogue between the planner and other providers, but the process of that interchange should be underscored.

The following summarizes the 79 key informant interviews, and four focus groups of professionals with regard to:

- ° unmet mental health needs of senior adults
- ° barriers to obtaining services
- ° training needs
- ° research priorities
- ° service organization suggestions

as identified during the interview process. This information was in response to the basic question:

"What are the unmet mental health needs of senior adults; considering mental health in its broadest context?" and probing based upon their answer(s). Probing included barriers to service use, geographic priorities, areas of collaboration and/or referral, waiting lists, etc.

The specific column identified as "focus group" notes each of these opportunities for input singularly; regardless of the number of individuals in the focus group identifying the problem. Thus in the ultimate ranking, these needs are given more weight as they reflect the input of more than one key informant. (Focus group size ranged from 8 to 26

participants; these groups are identified in Chapter 4 - Methodology).

Tables 15 - 19 summarize the results of these key informant interviews and focus groups on both a city-wide basis as well as neighborhood or county basis. The latter differentiation was important in selecting target areas for initial program start-up.

The "N" of 84 includes the 79 key informants, four focus groups and one group of attendees at a related professional conference, who, in sum, were treated as one focus group.

TABLE 15
Unmet Mental Health Needs of the Elderly, by City and Neighborhood
(N = 84)

Unmet Mental Health Needs/Service Needs	Total	Citywide	Neighborhood				Identified by Focus Group	Comment(s)
			1	2	3	4		
Mental health services to <u>homebound</u> , home evaluations	38	14	5	2	15		2	Include capacity to draw blood; see also homebound supportive services.
<u>Outpatient "clinic" services</u> with a <u>gero-psychiatric expertise</u> .	22	1	2	4	13	1	1	For other than a chronic mentally ill population, for Medicare/non-Medicaid including Soviet emigres.
<u>Day Treatment</u> Programs including Dementia HIV+/AIDS	15 4 1	5	3	1 1	5 3		1	
On-site services at senior centers, housing	14	8	1	3		2		
Psychiatric back-up/psychiatric services including ◦ for existing social service programs ◦ within Federation agencies' for-profit divisions ◦ home health care ◦ at adult day care programs	12 3 3 3 3	2 1	3 1 1 1		4 3 1 1 1		3 1 1	Potential for contracts with non-profit and proprietary homecare agencies
<u>Substance Abuse</u> , including ◦ Alcoholism ◦ Drug Abuse ◦ Mixed	9 6 2 1	7 4 2 1		2 2				

Table 15 (continued)

Unmet Mental Health Needs/Service Needs	Total	Citywide	Neighborhood				Identified by Focus Group	Comment(s)
			1	2	3	4		
Services for client/family member dyad with dementia								
Treatment of behavioral symptoms by a psychiatrist	5	2		1	1		1	
Change from a DOMH reimbursed service	5	5						
Group home/residence for early-mid stages	4	2		1	1			
Services at early disease stage	7	4		2				
Caregiver needs including coping strategies	3	1		1	1			
Dysfunctional caregivers-therapeutic interventions	1	1						
Caregiver support groups	8	3			4	1		Noted by Alzheimer's Assoc.
Support for home care worker	2	2						Including telephone support groups. By, for example, respite and/or support during home visit.
Case Management	8	6			1	1		
Consultation/education at senior centers, day centers	6	2		1	1	1	1	
Outreach	6	3	1		1		1	
Crisis mobile mental health team	4			1	1	1	1	
<u>Group Services - "Therapeutic"</u>								
Elders abused	4	2	1				1	
HIV+/AIDS	2	2						May be overlap or transfer between framework of clinical and FLE groups.
Parents of CMI	8	4			2		2	
Alcoholics/Substance Abuse	2			1			1	
child who has died; "non-normative" bereavement	2	2						Also, other functionally dependent adult children.
Depressed older adults	1				1			

Unmet Mental Health Needs/Service Needs	Total	Citywide	Neighborhood				Identified by Focus Group	Comment(s)
			1	2	3	4		
Group Service/FLE/Self Help Education								
Bereavement groups (normative)	4	3		1			2	Evening groups, regularly scheduled with announcements, for minority groups.
Newly or planning to retire	3	1						
HIV+/AIDS education	1	1						
Soviet emigres	3	2			1			
Realities of entitlements	2			1	1			
Women living alone	1				1			
Caregiver (non-dementia)	1						1	
Grandparents in parental role	2	2						
Mid-life women (preventive)	2	1				1		
Representative payee, etc.	1	1						
Healthcare proxy	2	1				1		
Informal gatekeepers	1	1						
For the Homebound/Isolated								
Friendly visitors	5	1		1	2		1	
Telephone support groups/socialization	5	4					1	
Volunteer opportunities (need for)	3	3						
Representative payee/conservatorship	1				1			
Homeless, mentally ill	1		1					
Residential services for the chronically mentally ill	1			1				
Services for individuals with dual diagnoses	1		1					
Respite	1		1					
Deaf, mentally ill	1		1					

TABLE 16
Barriers to Obtaining Services by the City and Neighborhoods
(N = 84)

Barriers to Obtaining Services	Total	Citywide	Neighborhood				Identified by Focus Group	Comment(s)
			1	2	3	4		
Limited linkages and collaboration between programs and services	7	3	2		2			
Transportation	7	2		1	1		3	
Stigma associated with obtaining mental health services	6	4			1		1	Lack of informal networks to destigmatize service use exacerbates this.
Services that are not bilingual or culturally sensitive	6	3			2		1	Russian language (JCC focus group), bilingual Spanish, other emigree groups; one patient's suicidal ideation was missed via translation.
Undetected depression; better diagnosis by primary physician	5	3			2			
Difficulty in recruiting well-trained and qualified staff, willing to work with senior adults	5	5						Recognizes failure of graduate schools to adequately address "aging issues."
Physical access	3	1			2			
Ageist attitudes by providers	3	2			1			
Fees	3	1					2	
Expense of psychotropic medications, noncompliance with regimen	2	1			1			
Lack of knowledge of available resources	1	1						
Restrictive eligibility criteria	1				1			

Note: These are listed in descending order of importance based on total numbers of individuals or focus groups identifying as a priority.

TABLE 17
Specific Needs for Training as Identified by Key Informants and Focus Groups

Training Needs	Total	Comment(s)
Consistent with Agency standard for quality training: Non-mental health clinicians identification of mental illness, how to "handle in a normative setting"	10	Include issue of ageism and why bother with older adults.
For mental health clinicians	9	Key informants expressed desire to participate in Agency training programs.
Geriatric psychopharmacology	2	
Elder abuse	1	
Alcoholism	1	
Needs of soviet emigres within the existing aging network	1	

TABLE 18
Specific Research Priorities as Identified by Key Informants and Focus Groups
(N = 84)

<u>Research Priorities</u>	<u>Total</u>
Effective treatment modalities	5
Studies of the old-old	1
How do family reactions influence the course of care	1
Value of group therapy in the early stages of depression	1
Outcomes of home delivered services	1
Jewish caregivers and stressors	1

TABLE 19
 Suggestions for Organization of New Service Division
 as Identified During Open Ended Discussion
 (N = 84)

<u>Suggestions for Service Organization</u>	<u>Total</u>
Identify discrete workers/services as there is a relevant body of knowledge	2
Need for close affiliation with inpatient psychiatric facility	2
Use of psychiatric nurse clinician	2
Consider use of "mature workers"	1
Work with clients who are medically stable	1
Definition of Agency role	1
Reminders to senior clients and follow-up for "no shows"	1
Include screening for elder abuse	1
24-hour access	1
If referred by another agency, the client should <u>not</u> have to make the first contact	1

SERVICE PRIORITY RANKING

Utilizing the data obtained and detailed in this chapter of the report, unmet service needs (including training and research) were preliminarily categorized as "high," "medium" or "low" priorities for the Agency using "cut-off scores" of "10 - 38" for high; "4 - 8" for medium and less than "4" as low. Areas where Agency staff (either members of the Program Coordinating Committee or Agency staff currently working with older adults) gave a higher priority for service development than the key informants and focus groups were:

- ° Friendly visitors, telephone supports
- ° Respite
- ° Caregiver supports
- ° Mental health services for early-stage dementia clients
- ° Case management
- ° Volunteer opportunities
- ° Residential services for the homeless mentally ill and chronically mentally ill populations

These higher and different rankings were reflected in the version of the summary of priorities formally presented to the Program Coordinating Committee. The Program Coordinating Committee accepted the services rankings as presented (as detailed in Table 20) which reflected these higher rankings and consistency with

Agency mission and expertise. Low priorities can be viewed as those beyond the Agency's purview and competency and/or of limited need. The acceptance of the service ranking as presented reflected, in the author's view, the fact that each member of the PCC was given an opportunity for input, was assisted in completing their rankings if the process was totally unfamiliar to them, and the fact that there was consistency between what they heard during key informant interviews, and read in materials that were distributed. In addition, where PCC members' views were divergent, the researcher met with them individually to interpret realities of service provision and access, need, funding and other concerns.

Even without such discussions there was fundamental agreement with the proposed priority schema; differences were a function of lack of knowledge or concern about how services would be delivered - not if they were needed.

There was also discussion at the PCC meeting at which this was presented suggesting both an intellectual, emotional and clinical investment in the process.

TABLE 20

**Summary Services, Training, Research Priorities and
Barriers to Service Categorized as
"High," "Medium" or "Low" Priorities**

I. UNMET SERVICE NEEDS		
HIGH	MEDIUM	LOW
Outpatient clinic services with a geropsychiatric expertise		
Onsite services at e.g. senior centers and housing	Consultation/education to senior centers, housing, etc.	
	Outreach	
Mental health services to the homebound, home evaluations		Crisis mobile, mental health team
	Friendly visitors, telephone support groups	
Psychiatric back-up for existing social, health and home care services		
	Respite	
Day treatment programs • late onset, chronic mental illness, • dementia • HIV+/AIDS	Volunteer opportunities	Services for individuals with dual diagnosis (MH/DD)
Services for family members whose relatives have dementia • Caregiver supports • Mental health services - early stage	Services for family members who relatives have dementia • Group home • Treatment for behavioral symptoms	
Case management related to mental health clients	Substance abuse services	Representative payee/conservator
	Therapeutic groups, education/FLE, self help groups, services for older adults who are parents of functionally dependent adult children.	
	Residential services for CMI, homeless, mentally ill	

II. BARRIERS TO SERVICE USE		
HIGH	MEDIUM	LOW
	Stigma	Physical access
	Difficulty in recruiting qualified staff	Ageist attitudes by providers
	Transportation	Lack of knowledge of available resources
Limited linkages and collaboration		Fees
Services that are not bilingual or culturally sensitive, especially Soviet emigres		Expense of psychotropic medication
	Undetected depression	Noncompliance with medication
		Restrictive eligibility criteria
III. TRAINING		
HIGH	MEDIUM	LOW
Non-mental health clinicians (aging)		Geriatric psychopharmacology
Mental health clinicians (no-aging expertise)		
Elder abuse		
Alcoholism		
Needs of Soviet emigres within the existing aging network		
IV. RESEARCH		
HIGH	MEDIUM	LOW
	Effective treatment modalities	Studies of the old-old
		Stressors
		Caregiver responses

PROGRAM DEVELOPMENT RECOMMENDATIONS

To understand the context of the program development recommendations which follow, the context of current service delivery to older adults by the Agency is relevant.

Current Service Provision by the Agency

As of November 1, 1991, there were 268 individuals 65+ receiving treatment through the various Agency divisions. They ranged in age from 65 - 89 years with an average age of 71.8 years (see Table 21). The majority of these clients (64.5%) are seen within the Community Services Division where there are two groups for senior adults within the existing clinic structure and another worker outstationed three hours per week at a local senior center. In addition, there is presently one full-time worker outstationed between two senior centers providing onsite treatment to clients at those programs.

Approximately one-quarter of older adult clients are chronically mentally ill and are treated within that Division.

TABLE 21

Overview: clients 65+ (as of November 1, 1991)

Number =	268
Age Range =	65 - 89 years
Average Age =	71.8 years

Distribution by Program Type

Clinics and other community programs*	173 (64.5%)
Chronically mentally ill	70 (26.1%)
Other (preventive services, homelessness prevention project, Soviet emigres)	25 (9.3%)

* Includes off-site programs at senior centers.

Seventy-three percent of all senior adult clients seen by the Agency are female⁹. The majority of senior adults served are White (85.1%), with 8.4% Black, 4.8% Hispanic, and 1.6% "other." Of the 268 senior adult clients, information about their religion is known for 236. Across programs, 77% are Jewish, 14.4% Catholic, 4.7% Protestant, and 3.8% either "other" or had no religion.

It should be noted that services provided onsite at three local Y's and senior centers began at their request a decade ago in recognition of a significant change in their population. Specifically, workers at the senior centers were identifying individuals who were exhibiting symptoms of depression, remaining on the program periphery, no longer participating in activities, no longer attending the center, and/or becoming "behavioral problems."

It was requested that Agency staff provide consultation and education to the senior workers at these programs to enhance their ability to manage programs and provide optimal services. That consultation and education expanded and workers were then outstationed at the Y's and senior centers to provide direct service. Depending upon the year and specific funding available, such workers have been outstationed at as many as six senior programs.

⁹ In 1990, 59.7% of the population 65+ (nationally) were female. The ratio of women to men increases with age; 72.1% of the population 85+ are female (AARP, 1991). Local age and ethnic data for senior adults based upon the 1990 census is not yet available.

Services to the Chronically Mentally Ill

Presently, a significant number of elderly individuals, in relation to the total number served, (68 including both the mental health clinic and continuing day treatment program) receive services. It was noted by program staff that with individuals over the age of 60 there is a greater likelihood of client preference for treatment in individual rather than group settings. For many, visits with the social worker and monthly medication reviews with the psychiatrist make "the difference in their ability to remain in the adult homes rather than require state hospitalization and/or nursing home care." However, it has been noted, that these individuals are more isolated, and less willing to participate in the continuing day treatment program in the adjacent building as a function of their depression, apathy, burnout, and staffs' notion that perhaps that program is overstimulating for senior adults.

In addition to the chronically mentally ill themselves, it is of concern to the Agency that family members of the chronically mentally ill also require supports. To date, efforts to reach that population have been unsuccessful, largely a function of the amount of staff time required.

Jewish Family Life Education (JFLE)

It is estimated that between July 1, 1990 and June 30, 1991, there were 88 Jewish Family Life Education groups reaching approximately 1335 older adults. These educational workshops, lectures and discussion groups address "typical" life cycle experiences. Topics have included widows' groups, grandparenting skills, coping with stress, retirement, positive aging, prescription and over-the-counter drugs, alternative life styles for older persons, reminiscence, etc. In addition, eight groups were developed for adult child caregivers to support their "sandwich generation" status.

Jewish Conciliation Board

Within the context of the Jewish Conciliation Board whose purpose is the evaluation and conciliation of disputes within the Jewish community, including interpersonal, familial, marital, communal and business conflicts, 40% of the clients seen during calendar year 1991 were age 60 and over (n = 27). These cases have included, for example:

- ° Disputes with an adult child where the adult child wants the senior adult to dispose of property or handle their finances in a particular way that is not consistent with the senior adult's thinking.
- ° Grandparent's visitation rights.

- ° Seniors wanting to direct trust funds for their adult children.

The value of the Jewish Conciliation Board is that these problems are resolved within a casework frame or format; none of these family issues have required arbitration.

Other

With the cooperation of a local medical center, the Agency is in the process of developing a support group for grandparents raising their grandchildren as a consequence of the parent's death from AIDS. Work with grandparents also exists in the Prevention (of foster care) Unit.

Finally, the Employee Assistance Program of the Agency has worked with numerous adult children in addressing the needs of their frail parent(s), its impact upon them/their families and their work productivity. The number of these cases are not reflected in this data as they are not readily accessible.

Professional Education

One of the most popular seminars offered via the Agency's Educational Institute is "Working with Families of the Aged." This year, 26 individuals attended that particular session. It is noteworthy that this seminar attracted social work,

nursing and recreation therapy staff, underscoring the interdisciplinary nature of aging services.

Staff

Identification of Agency personnel with an expressed interest in working with the elderly has been accomplished via:

1. Their clients at the Agency.
2. The JFLE seminars and groups conducted and group leaders.
3. An indication of such an interest within the Agency's private practice referral log (of the 81 individuals on the current referral log, 28 (35%) indicated they would treat geriatric clients).

Through this mechanism:

- ° Four psychiatrists
- ° Four psychologists
- ° Forty-six social workers with a theoretic interest in working with older adults have been identified. It is recognized that a number of Agency staff have indicated an interest/willingness/expertise in geriatric mental health as a means by which to give the development/expansion of their private practices the greatest potential. More realistically there are 10 - 15 social workers with a real interest in this population.

SPECIFIC SERVICE DEVELOPMENT, IMPLEMENTATION AND INTEGRATION

The needs assessment process including the literature review provided the necessary data for the development of a continuum of care for older adults with chronic and/or late-onset mental illness as well as a mechanism to provide preventive services. Table 22 outlines this continuum which broadly includes:

- ° Preventive services
- ° Clinical services in a normative environment
- ° Clinical services within clinic settings
- ° Day programs
- ° Respite
- ° Residential services

There is the clear recognition that outreach, training, research, and information dissemination are relevant supports and professional responsibilities across and throughout the continuum.

The continuum of care for the elderly as proposed is consistent with the mission of the Agency and builds upon its current functional/division structure. The implementation of specific services within the continuum will also build upon the knowledge obtained during the planning from existing, exemplary aging-mental health programs including for example, creation of a discrete unit, culturally sensitive programs,

linkages and collaboration with other providers, and well-trained staff.

TABLE 22

Proposed Continuum of Care for Mental Health Services for the Elderly

Preventive Services

- Family Life Education
- Short-term support groups
- Friendly visitors
- Telephone support groups
- Caregiver support groups
- Self help groups
- Intergenerational programs

Clinical Treatment Services

- Clinical services in a normative environment
 - senior centers
 - housing
 - psychiatric backup for existing social, and health services
- Clinical services
 - at home
 - back up psychiatric services for home care programs
- Clinical services at traditional clinic settings
- Case management
- Substance abuse services
- Elder abuse assessment and intervention

Day Programs

- Continuing Day Treatment
- Social day care
- Special day care
 - dementia
 - HIV+/AIDS
- Respite, day

Residential Programs

- Homeless mentally ill
- CMI
- Early-mid stage dementia
- Respite

Outreach, training, research, information dissemination will be integral components of all services as appropriate.

Implementation

Implementation and the actual creation of the Division of Services for the Older Adult is designed to build upon identified needs while also recognizing the realities of funding stream priorities and regulatory constraints. Nonetheless, beginning with the services ranked as high priorities, a 6-month, 1-3 year and 3-5 year plan as noted below was approved as presented to the Executive Vice President, PCC and other relevant middle and executive level management and clinical staff. The short-term objectives were for the six months of July 1 - December 30, 1992.

Short-Term Objectives

1. Creation of a Divisional Committee (July).
2. Trial within one geographic area of active outreach including inter-agency linkages; discussion of interdivisional responsibilities and training.
3. Reaffirmation of specific aging services providers/experts (at least one per office) within the Community Services - Clinic system.
4. Initiation of Medicare and Medigap billing; (October 1, 1992); related training (September 1992).
5. Trial of an "aging newsletter" for staff (August-September).

6. Identification of models for onsite mental health services at senior centers, meet with Jewish Community Center Advisory group¹⁰, identification of senior center priorities and submittal of grant application for same with services to begin by year-end. (This recognizes the need to address regulations, potential CONs and/or group practice model.)
7. Submittal of at least five grant applications for services noted in continuum (December).
8. Submittal of plan to Board of Directors (Fall).
9. Simple brochure describing aging services (September).
10. Communication with key informants (with brochure) for June 28th conference for Older Adults who are parents of Chronically Mentally Ill Adult Children¹¹ (June).
11. Begin pilot services for senior Soviet emigres in geographic areas of highest concentration (Fall).
12. Identification of a format via which the aging services division can meet to discuss representation at various aging task forces, marketing, clinical techniques, etc. (October).
13. Trial of JFLE brochure with courses and short-term groups geared to the aged and their caregivers (Fall).
14. Identification/marketing of dependent care (eldercare) as a product of the EAP division.
15. Kick-off of relationship with local School of Social Work with major joint conference.

¹⁰ Developed as outgrowth of focus group.

¹¹ An interagency effort and outgrowth of this planning.

16. Planning for course sequence (Spring, 1993) on geriatric mental health with that school of social work.
17. Delineate the specific roles of psychiatry and psychology and related training needs. (Fall)
18. Review existing case record file formats (interdivisionally as appropriate) and identify supplemental standardized, reliable and valid instruments for, for example depression, dementia and abuse. (October)
19. Develop format for generation of basic data on older adults' use of service.
20. Complete evaluation of Friendly Visitor requests from Joint Passover Outreach and work with other relevant aging-agency re: service delivery and collaboration.

It is recognized that planning and evaluation are dynamic processes. With the rapidly changing external environment it seemed unproductive to articulate a series of specific objectives beyond December, 1992, but rather to categorize them as Mid and Long-range objectives recognizing that both the continuum of services chart as well as the complementary high, medium and low priorities schema would provide the framework for service expansion.

Mid-Range Objectives

1. Creation of a post-masters certificate in Mental Health Services to the Aged with the local School of Social Work.
2. Integration of aging information/case material into Agency inservice training.
3. Geriatric expertise at all clinics; either directly or via alternative model of service delivery.
4. Geriatric SWAT team for home visits.
5. Psychiatric back-up for at least two existing (other agencies) social/aging/health/homecare programs.
6. Development of day treatment program for either HIV+/AIDS or early-mid dementia, with related caregiver supports.
7. Develop expertise in substance abuse and elder abuse identification and treatment.
8. Evaluate potential for a fellow in geriatric psychiatry.
9. Implement those new services for which funding has been obtained if not reflected above.

Long-Range Objectives

1. Development of residential and residential respite alternatives.
2. Major research initiative assessing impact of alternative treatment approaches.
3. Begin evaluation of older adult OMR/DD needs.

Implementation and modification of these objectives will, by necessity, reflect funding opportunities, the evaluation of the success of the Division, and input from the Divisional Committee.

Chapter 6: Findings - Can and How Do Agencies Plan?

The most significant findings, as the reader has concluded, are that this needs assessment and planning process were completed:

1. Consistent with the "plan to plan," within the original proposed and agreed upon timeframe (i.e. six - nine months).
2. Using the methodology articulated at the outset by the researcher who had then only minimal knowledge of the Agency.
3. With positive response and feedback by the Agency's middle and executive level management.
4. Relating to both internal and external publics.
5. With the support and tacit approval of the Board of Directors.
6. Cooperatively with the other community-based Federation aging-agencies.
7. Cooperatively with the support of other aging, health, mental health and social service agencies in the community.
8. Relatedly, with the ability to positively market the Agency to the larger mental health and aging provider communities.

9. With the conclusion by the Agency CEO that this process was, in fact, a model for planning.

The needs assessment process clearly informed the establishment of program priorities and in the context did not resemble, at all, the "garbage can model" of planning (Table 20). By using a system of "high," "medium" and "low" priorities, operationalization of a specific program within, for example, the high-ranked group will be a function of funding opportunities and realities - a notion the PCC understands well.

AGENCY IMPEDIMENTS AND SUPPORTS

In the development of the original protocol for this study, there were a number of potential problems anticipated in the conducting of the needs assessment and planning study. The anticipated planning impediments are compared to their actual impact on the planning process below.

1. Limited clerical supports: Clerical supports were a problem, however more so from the perspective of word processing software limitations and lack of experience on the part of the clerical staff assigned in completing charts, questionnaires and documents of significant lengths. This is consistent with an agency culture that has not been based on extensive written communication. In addition, clinical

expertise has been disseminated in workshops and seminars more extensively than through journal articles.

2. Pressure to achieve foundation support for the Division prior to the completion of the needs assessment and the identification of priorities: There was periodic pressure from the CEO to develop eleemosynary sources of funding and to quantify the impact of Medicare as a reimbursement stream. This was consistent with his original perspective that program development would begin immediately. From a practical perspective, completion of the literature review at a very early stage in the planning process and the overwhelming need for services to the home-bound senior as well as to seniors in normative (senior center and housing programs) environments, enabled a "generic approach" to grant development for foundations support to be utilized. With the assistance of the Agency's Development Consultant, one significant contribution was secured and two foundation applications were submitted prior to the completion of the planning study. It is understood that with the study completed, that the generic grant application will be revised, to reflect the results of this planning effort and potential interagency collaborations. It should be noted that a significant amount of time was spent with the Agency's Development Consultant to secure her support for this Division and the manner in which an endowment could be developed. Discussions included need, content, program goals and foundation supports.

3. The lack of familiarity with and potential resentment of a rational needs assessment process on the part of the researcher's peers, other members of the PCC, and Agency middle-management and line staff: This was viewed at least by the PCC, as an extraordinarily positive process. These staff indicated that if other Agency divisions were formed in this manner, middle management and line staff "burnout" might have been prevented; and there would have been clarity as to direction and ultimate sources of funding which would have been "reassuring." There was no resentment (at least overtly or that this planner could identify) of the expenditure of funds that were used for this planning process or of a Division head position with a "less demanding" job. Two other directors have expressed an interest in completing a needs assessment and planning process for their own divisions.

4. The Agency had recently undergone a major reorganization with a change in CEO: There were no implications for this specific project; professional staff were still in the process of sorting out for themselves whether there would be greater participation in decision-making with this major organizational change. However, there was a general "sorting out" of responsibilities and priorities which impacted on all Agency activities. Creativity seemed more minimal at the planning process' inception as was management cohesiveness.

Unanticipated impediments to the completion of this needs assessment and planning process included:

1. The Agency's MIS data was not as useful as anticipated, as the data base, includes at this time, only age and demographic characteristics. Diagnosis, length of stay within the program, treatment goals and approaches including medications are not included within the existing system. At the time of this planning process a conversion to a new MIS system (which theoretically will include this data) was underway. In addition to its lack of usefulness as a planning tool, line staffs' resentment and frustration with regard to this change to a new MIS system preoccupied middle management making them both less accessible as well as lowering the priority of this planning as it did not impact on their day-to-day function. Further, service to older adults became linked more to the implications of the tracking of Medicare eligible services, and the ability of MIS to create a viable system for this, than to need and clinical expertise. There was clear confusion of means and ends, from the Assistant Director for Community Services to individual office managers and fee clerks.

2. The data from the Jewish Information and Referral Service was not readily available in cross-tabulated form. Consequently, requests for information by individuals over the age of 65 and the type of information requested was not available. This had to be

tabulated by hand. It should be noted that when completed this was returned to JIRS for their use as a potential planning tool - both in terms of the specific information obtained, but also to bring to their attention the poor software/programming design which limits its usefulness.

3. The Agency's Director of Program Development was out ill for several weeks at the beginning of the needs assessment and planning study. As he had played a critical role in the initial development of services on-site at senior centers, meeting with those direct service staff was postponed until he had returned to work. The negative impact of this was that the "grapevine" and informal communications network was much more efficient than the Agency's formal means of communication. This, as could be expected, had a negative impact upon several staff members who felt as if they were being by-passed and their knowledge, experience, contacts and loyalty were not valued.

4. As indicated earlier, the Agency has ten licensed outpatient mental health clinics. During the first three months of this researcher's planning efforts, two new regional directors were appointed (there are four in total), and two clinic directors reassigned. Consequently, planning for this new Division was not their priority; they lacked familiarity with their new

regions and wanted and needed to establish themselves in their new roles. Even with the plan accepted and in the process of implementation, there is still one geographic area, albeit that with the smallest aging population, that was not integrated into the key informant interview process. It is anticipated that these contacts will be made in August-September.

5. There has been a change in State regulations that limit services that can be provided by mental health clinics off-site without satellite licensure. There is a current moratorium, however, on the submittal of certificate of need applications for satellite licensed clinics. This presents a critical problem in program implementation, which is being addressed as part of the implementation phase.

6. In July of 1990, Medicare regulations changed significantly allowing for the reimbursement of social workers and licensed psychologists. Unfortunately, the local Medicare fiscal intermediary did not understand these new regulations and hence was unable to provide clarity in terms of reimbursement requirements, processes for becoming a Medicare provider, etc.

7. There was also clear and articulated ageist attitudes on the part of some clinic directors and line staff.

8. There was no clear Agency policy with regard to age as a criteria for eligibility for receipt of service.

9. There was no means by which to evaluate the existing waiting list for service for numbers of older adult clients, presenting complaints or caregiver needs.

10. Agency culture is division-bound; that is discussions at the program director level (who report to division directors) are focussed primarily on division activities. PCC members did not use the opportunities of their staff meetings to share information about this new division or related planning.

11. As a related example, the ten licensed outpatient clinic directors meet with "their" Assistant Executive Director monthly; the Regional Directors meet with him weekly. This separate and distinct administrative chain was not easily accessible; to date this planner has not been invited to meet with all ten clinic directors. Medicare billing may be the subject that facilitates such a meeting.

Unanticipated Planning Supports

Despite these impediments a number of unanticipated supports were of significant assistance.

1. The Agency has, at its central office, a modest but quite useful social work library as well as a librarian who is extraordinarily helpful in obtaining copies of articles from the interlibrary loan system. Needless to

say, this provided a significant savings of time to this researcher.

2. In addition to the Development Consultant, there is also a small Development Department which provided support for the identification of foundations with an interest in aging, mental health, programs under Jewish auspices, and/or programs in the geographic region. Membership in the Foundation Center facilitated this process.

3. The Public Relations Department added to the legitimacy of the program in the Agency's newsletter by announcing the creation of the Division of Mental Health Services to the Elderly, an announcement card of this researcher's appointment as the Division Director, and the development of a brochure for the conference co-sponsored by this Agency and several other community organizations for seniors whose adult children have chronic mental illness. This Department's existence and support was a clear asset.

4. The Agency's General Counsel identified an attorney, interested in doing pro bono work for the Agency. Her role focused on understanding the Medicare regulations with regard to reimbursement for social work and clinical psychologists and participating in the chart audit on this subject to identify the extent of Medicare as a potential revenue stream.

5. Unrelated to the Agency and more related to the researcher, was her contact with a high level official at the Regional Health Care Financing Administration Office who became the contact for questions regarding Medicare reimbursement. Without this contact, there would have remained a series of questions the fiscal intermediary could not (or perhaps simply would not do the research to) answer. For example, how is a "collateral visit" defined; is marital therapy a covered service under Medicare?

6. As evidence of the CEO's commitment to this Division, he has had this researcher appointed as a member of or chair of interagency committees on aging issues, whenever the opportunity presents itself.

7. Federation of Jewish Philanthropies was also more helpful and interested in the process than anticipated. Specifically, by convening two of the focus groups:

a. Emigres, aged 65+, from the former Soviet Union
and

b. Jewish Community Centers and Senior Center
directors;

they gave their imprimatur to this planning endeavor and in so doing also gave credibility to the process and ultimate planning report.

Agency Structure

As a large human service organization, there already existed within the Agency, standing management and program development/coordination committees. Using the existing structure (in this case the Program Coordinating Committee) to form an "in-house advisory group" supports the notion of the new Division being an equal among long-standing Divisions. The PCC has regular meeting times and is recognized as the highest level clinical/programmatic/management group. Such an organizational structure facilitated planning by: legitimatizing discussion at meetings; having regular access to key staff as a follow-up to such discussion (e.g. visits to key informants); and not creating feelings of burden by creating yet another committee. As a cohesive group, it functioned as Homans (1958) suggested by valuing the sentiment or activity of its members and by having frequent interactions between its members.

However, enhancing the PCC with the Director of Finance, regional clinical directors and several current aging-services workers during relevant discussions about the project would have enhanced the planning dynamics, expanded the base of advocates for the service within the Agency and linked often disparate internal publics. Inasmuch as some services will be provided via other divisions (e.g. via the clinic system) a matrix model will be necessary for administration. If regular meetings of workers providing services to older adults could

have been a part of the planning, line staff resentment, in the form of resistance to another priority or target population, reluctance to provide holistic social and mental health services, might have been avoided.

It is this Agency's practice to establish a Divisional Committee to oversee the function of the Division, fund raise for the Division and advocate for the Division with the entire Board of Directors. Inasmuch as the Board of Directors had approved the creation of this new Division, and this planner's employ, the technomethodological aspects of planning were viewed as a clear staff responsibility. This Agency, and its Board, believe in the dignity of all individuals, a respect for the demands on the caregiver, a commitment to choice in service setting, a belief in a continuum of care, an interest in innovation, a clear commitment to training, and an interest in research and quality social work practice. These guidelines provided standards for the planning effort.

One report was made to the Board approximately half-way through the planning process, as a means by which to reaffirm their commitment, and give "life and reality" to what might otherwise have been viewed as a dull endeavor (and consequently not as important as other divisions). Clearly, Board approval and involvement, consistent with an agency's usual practice, is important.

Even given the size and complexity of this Agency, the proportion of time spent with "internal publics" (65.5%) was surprisingly high. However orientation to the Agency, identifying areas of shared interest(s) between the "Aging Division" and other divisions, internal marketing of need and commonality of Agency goals, preparation for and completion of data collection from the clinics' medical records and participation in overall Agency management functions are time consuming tasks. Relatedly, the Agency is beginning to grapple with the issue of matrix management -for example in which division does a counseling program for older adults who are HIV+, PWAs or PLWA fit - the clinic system and division, the AIDS Division or the Older Adult Division? Until such issues are resolved, internal communication and negotiation is a time consuming task.

The remaining planning time, i.e. 34.5% was spent with external publics, primarily individuals who are knowledgeable about this population's needs, practice models, and regulatory and reimbursement issues. It was particularly important to begin to attend the local geriatric Mental Health Committee and assure that the Agency was represented in all neighborhoods. That attendance and participation was a clear statement to the geriatric/mental health communities that the Agency was serious about its intent and knowledgeable about the subject.

Finally, as a newcomer to a large organization, the ability to establish one's legitimacy through knowledge is essential. Within two weeks of this planner joining the staff, questions from other staff members about their aging parent(s) surfaced; it took two months for adequate trust to be established to be asked to respond to the needs and questions within the EAP. In the context of this project, it was knowledge about aging, in a non-aging host setting, that was key.

Chapter 7: Discussion and Practice Principles

This chapter will address: the process of the student as both the planner and observer/researcher; a critical evaluation of the process; the model of planning most closely approximated; generalizability and limitations of the case study approach; and a series of practice guidelines and principles.

OVERVIEW OF THE PROCESS

One concern identified in the development of the protocol for this project was the impact and ramifications of the student as both the planner and the researcher. Patton (1990) suggests that personal contact by the researcher does, in fact, provide insight and allows the researcher to get close to the phenomena under study. In some cases, the researcher's personal experiences and insights are an important part of the inquiry and critical to the understanding of the phenomena. In this case it was a useful model.

This Agency's policies require that approval for the conduct of any research be obtained by the Chief Psychologist, who also acts as the Director of Research. That and discussion with the researcher's supervisor of the plan to

conduct this study were the only direct occasions of the potentially overlapping activities of the needs assessment and planning process and its study. To the degree that it was consciously possible, the dissertation component was structured, approved and "put aside" (with the exception of the maintenance of the log and related anecdotal notes) to enable completion of the needs assessment and planning study in what proved to be a viable and unbiased manner.

Completing a needs assessment requires both technomethodologic and sociopolitical skills. Even with a "plan to plan" in place, there is a constant evaluation of its continued relevance and appropriate sequencing. For example, "how many key informant interviews are adequate?"; "Is a mail survey a useful task?"

Schon (1983) suggests that when a practitioner "reflects-in-action" that person becomes a researcher in the practice context. Completion of the needs assessment and planning process were operationalized as opportunities to "reflect-in-action." In that context, means and ends are not kept separate, but rather, defined interactively as the researcher frames a situation. There is not a separation of thinking from doing - experimenting is rather a kind of action - thus reflection-in-action can proceed even in situations of uncertainty or uniqueness.

While not generally accepted as a legitimate form of professional knowing, and sometimes viewed as a threat or sign of weakness, Schon (1983) further suggests that the study of reflection-in-action is critically important.

"The dilemma of rigor or relevance may be dissolved if we can develop an epistemology of practice which places technical problem-solving within a broader context of reflective inquiry and shows how reflection-in-action may be rigorous in its own right and links the art of practice and uncertainty...to the scientist's art of research."

In this context, reflection-in-action was a conscious thought process, representing a level of abstract continuous evaluation, rather than rote adherence to the original "plan to plan." It incorporates both the technomethodologic and sociopolitical aspects of planning, linking these components in discussions and presentations to internal and external publics.

Heuristic searching is the category of practice which Harrison (1987) suggests as descriptive of the creative reflective practice phenomena. It consists, in his view of

"questions to oneself concerning the possible chain of events, including unpredictable or uncontrollable forces in operation...This questioning and searching for explanations is not in fact limited to thinking by oneself. It involves dialogues with colleagues, supervisors, and clients themselves."

Those dialogues served not only to problem-solve, but as a means by which to accomplish internal marketing tasks e.g. discuss need, market niche, community response, promotion, technique, etc.

As detailed in Chapters 5 and 6 the researcher's constant reflection-in-action resulted in changes from the original protocol including:

- ° Addition of key informants based upon suggestions by other key informants and the literature. The researcher evaluates when the moment of redundancy has been reached, when the variety of program models have been seen and no new insights are gleaned.
- ° Consolidation of the key informant and site visit functions.
- ° Use of one consumer-based focus group is an example of taking advantage of positive opportunities and having the flexibility of style to do so.
- ° Changes in the order of task completion e.g. completion of the aging-terminology glossary early on in the process, when it became clear that aging services language is not always consistent with that of psychiatric social work.
- ° Creation of an Agency-based interdivisional Medicare Work Group to separate resistance to a new billing system from concerns about delivery of services to older adults. Observing that this phenomena was even occurring is an example of this level of conceptualization.
- ° Elimination of the study of Agency clients aged 50+.
- ° Elimination of comparison of local mental health usage patterns to national norms.

These changes all occurred in the "action present," that is the zone of time in which action can still make a difference in the situation (Schon, 1983).

Bernstein and Epstein (in press) link the use of the grounded theory approach to skillful administrative practice, which includes "a predisposition for handling and enjoying ambiguity, thinking inductively as well as deductively and taking intellectual and conceptual risks." In addition, there is an understanding that situations change, there is an emphasis on the interactive process, a recognition that one's work involves managing multiple relationships with people who do not necessarily share their objectives, and the premise that this approach should be applicable in practice. In this understanding are to be found the two important themes within this project, i.e. the importance of internal publics as a marketing constituency and the need to "reflect-in-action."

While Schon's notion of the reflective practitioner is not fully refined, this example of the planner as the practitioner, constantly able to evaluate the situation and change accordingly provides another example of the utility of this approach.

Practitioners can also reflect on their knowledge in practice. Sometimes in the relative tranquility of a post-mortem, practitioners can think of projects that they have undertaken or "lived through" and explore the understandings they have brought to their handling of the particular case

(Schon, 1983). In that context, this needs assessment and planning process would have benefitted by:

1. The inclusion of site visits and/or key informant interviews with agencies serving a greater proportion of minority clients.
2. The use of at least three other focus groups:
 - ° "Functionally independent" aged
 - ° Older adults with functionally dependent adult children
 - ° Adult children who are caregivers themselves
3. A presentation to the entire Agency Professional Council (this is defined as the approximately 75 individuals who coordinate and direct individual programs, residences and clinics) to describe the planning process.
4. Meeting with staff members (individually and as a group) who work with senior adults at least six weeks earlier in the planning process. This would have allowed for the separation of the information sharing and information gathering functions and potentially a greater sense of ownership of the plan as well as decreased personal anxiety about how the ultimate plan for this new Division would impact upon them as Agency workers.

5. The creation of a divisional newsletter within six weeks following the meeting with staff members working with older adults to highlight existing programs and staff and progress in planning.

6. Expansion of the staff work group beyond the PCC to include the Director of Finance, clinic regional directors and several line workers.

The noninclusion of experts in working with minority aging clients, reflects in retrospect, the Agency's desire for this Division to enhance its services to Jewish clients and hence created a more insular planning approach than the ultimate service framework will reflect. The lack of planned direct senior client input was a function of the planner's own unconscious ageist perspective and limited the personal dimension process for the planner, limited her ability to describe the problem in terms of individual cases, rather than statistics and "cold facts."

Expansion of the base of information flow throughout the Agency underscores the importance of the involvement of all levels of staff in the planning of a new division. Whether viewed as the sociopolitical dimension, internal marketing or a means by which to minimize resistance, this involvement is essential to both the planning and implementation phases.

Unfortunately, given this planner's own recent arrival at the Agency and the need to orient herself to it as a large, complex human service organization, it was impossible to

complete a force field analysis (Brager & Holloway, 1978) to analyze the critical actors and driving and restraining forces which would ultimately be related to the implementation of this Division. Similarly, it was difficult to assess the Agency's style early enough in the process with regard to information sharing and desire for input - and at what level of staff. Even raising the question was not productive as this was the Agency's first such self conscious planning effort and there was no organizational history to provide baseline data for comparison.

Finally, the impact of the Agency's reorganization was not clear. Knowing whom to speak with about what issue became very complex, especially to a newcomer to an organization as large as this one.

Landau (1969) suggests that large scale organizations tend to develop their own parallel circuits, not the least of which is the transformation of such "residual parts as informal groups" into constructive redundancies. He notes that this compensates for deficiencies within the formal organization, allows for flexible responses and facilitates creative potential. If there is no duplication or ambiguity an organization will neither be able to suppress nor generate alternate routes of action. Landau acknowledges that elimination of duplication and consolidation are powerful objectives with obvious appeal, but he also suggests that achievement of these objectives might deprive an agency of the

properties it needs most - those which allow rules to be broken and units to operate defectively without doing any critical injury to the agency as a whole. Again, the newness of the planner made an understanding of the informal systems difficult. The ability to understand the informal system was also complicated by the Agency's reorganization as informal groupings were changing as this planning was developing.

Unanticipated Benefits of the Planning Process

1. As a consequence of a meeting with the area agency on aging (AAA) regarding unmet mental health needs of senior adults, the AAA is in the process of completing a survey of senior centers and home care programs regarding the presence/absence of mental health impairments in their clientele.
2. The Agency recognizes its need to enhance its program development approaches; as one step Dialog, a computerized literature search tool has been introduced.
3. The Agency Administration, PCC and Board President have identified the planning process as a "model for planning," at meetings of the Board of Directors, at Federation of Jewish Philanthropies, at the AAA, Department of Mental Hygiene, etc. Certainly while clear support for the outcome of the planning was a goal, the degree of positive response to the process itself was

unanticipated. However legitimatizing such a planning framework:

- ° enhances the outcome of the process including the importance of services to an older adult cohort;
- ° enhances the planner/researcher's professional status in the Agency;
- ° provides background for foundation and other grant requests and enhances the "product" for the Development Department.

The planning process provided an opportunity for collective vision, collaboration, and entrepreneurship in the creation of a new Division and knowledge-based planning. While not a manifest goal, the planning effort recognized that human service organizations are facing increased competition in the market place. Funding is limited; organizations are expanding into unfamiliar territory, offering services which often put them into direct competition with sister organizations. Thus innovation is a requirement for organizations who want to remain viable. In addition,

- a. There must be a commitment to a focused vision.
- b. A respect for people served.
- c. A nurturing work environment, high standards for outcome.
- d. A high functioning Board of Directors.
- e. A high level of collaboration.
- f. Entrepreneurship is encouraged.

g. There is also a recognition that if you "don't know what is happening at the cutting edge in your field, you can't take that innovative, pioneering step into the unknown and untried (Carl & Stokes, 1991).

THE PLANNING MODEL

In analyzing the process, Etzioni's (1967) mixed scanning approach combined with Ham and Hill's (1983) concept of twinning proved to be the planning model closest to that used in this case study. Mixed scanning provided:

"a particular procedure for the collection of information,...a strategy about the allocation of resources...and-we shall see-guidelines for the relations between the two. The strategy provides a detailed "rationalistic" examination of some sectors - which, unlike the exhaustive examination of the entire area, is feasible - with a "truncated" review of other sectors."

In the exploration of mixed scanning, it is essential to differentiate fundamental decisions from incremental ones. For example, this distinguishes decisions to create a distinct division for mental health services for older adults which would include a continuum of care, and the recognition of the degree of unmet needs from questions related to, in which neighborhood in which to begin services and how to approach that goal. Etzioni (1967) further suggests, and it is this planner's experience, that incrementalism reduces the unrealistic aspects of rationalism by limiting the details required in fundamental decisions and "contextuating

rationalism helps to overcome the conservative slant of incrementalism by exploring longer-run alternatives."

Jansson (1984) also notes that it is the scanning phase that "undergirds all others...further, issues raised during the scanning phase are often associated with controversy during the legitimization phase linking planning to the implementation." This experience is consistent with Ham and Hill's (1983) suggestion that decision-makers may find the twin strategies of overall scanning followed by a more detailed exploration of specific problems to be a useful and realistic way of proceeding.

Relatedly, Zuza (1985) suggests that planning does not end once a planning document is completed; the essence or value of such planning lies in the ongoing process of being aware of and responding to future opportunities and threats, not merely in producing a product. There are interesting parallels to public policy analysis and the role of the analyst therein.

Planning and Policy Analysis Parallels

In this context, the works of Gilbert and Specht, Rein, Wildavsky and Gergen are relevant. Their collective works provide the theme of the importance of knowledge-based planning, proactive feasibility, incremental approaches in concert with values and cultural understanding, respect for

the processes of coalition development, consensus building, institutional sanction and supervision/management of the implementation phase.

Gilbert and Specht (1974) offer an intellectual component for policy analysis or planning. For them, social welfare is seen as choices among principles or guidelines to determine what benefits are to be offered, to whom they are offered, how these benefits are to be delivered and how they are to be financed. Their model is intellectual and knowledge-based, consistent with the concept that much of our "theory-derived knowledge" with regard to social welfare is fragmented and only partially verified.

Kahn (1969) and Moccoby, Kahn and Everett (1983) suggest a variety of concrete approaches via which to obtain knowledge including statistical theories, special studies and surveys, social statistics and projections, use of social indicators, literature review, evaluation studies, key informant interviews, and resource inventories. The goal of these approaches is to define the problem, diagnose the cause, seek relevant theories, obtain realistic estimates of scope and scale, inventory resources and estimate consequences of possible interventions. This model is driven by a desire to plan; not necessarily to create change or improvements.

This planning experience suggests, however, that too much power is given to the intellectual processes. In fact, Kahn (1969) suggests that planning is a "developmental process in

which several levels of intellectual undertaking are all in constant interaction." It lacks emotion, guidelines for action and a consideration of the historical context and political climate. However, it does offer a frame for guiding trade-offs and decisions as articulated by Rein, based upon both values and implications.

Rein and Schon (1977) begin by offering a useful schema for the definition of the problem. The context of naming/framing a problem and story-telling creates a potential link for public recognition, and adoption and constructively creates the problem definition which has hierarchal relations. Cohen (1976) illustrates the effectiveness of problem framing using loss as a theme - which is particularly relevant for older adults - loss of a sense of value, loss of the nuclear family, tradition and community. With such an approach, reality and emotion can be linked for the development of a support base. Rein and Schon (1977) suggest that there are different weighting schemes for judging the adequacy of a problem definition: plausibility, consistency, capacity to lead to action, value implication, beauty and testability - an openness to learning through the correction of thought by experience. Rein and Schon provide for pilot studies, experiments and increments within the context of problem testability. Their willingness to include incremental thought and approach is useful.

Wildavsky (1979) is a pragmatist: he notes that "feasibility is part of morality". In this society, Wildavsky states there are no permanent solutions, but rather permanent problems. His analysis of "what are we currently doing?" is followed by an assessment of "what is feasible?" and "will this improve society?" Clearly, his model is incremental, based upon the analysis of current policies and programs and successes therein. Incrementalism is urged as a way to continuously learn, with the recognition that we can never fully predict or know, to maintain or obtain public support and successfully link solutions. In this way he and Zuza (1985) share the same approach - that planning is not a time limited activity.

It is Gergen (1968) who believes that the real activity begins with implementation, including identification of leaders, understanding of the power base, consortia development, etc. For Gergen, the real skill is in the social process.

With this discussion of planning and policy analysis parallels as a backdrop, an analysis of this planning process concludes that planning (like policy analysis) is an intellectual process embedded in a social process, which must be understood in terms of its historic context, the present and the future. Marketing as an overlay to social planning respects both the intellectual and the social through its identification of the role of multiple publics and the

priority given to the interactions necessary for their involvement.

How does the intellectual or technomethodologic process interact with the social or sociopolitical process - both within the agency and on an interagency basis? This case study Agency, like other organizations, is held together by a normative glue, i.e. by the sharing of certain important beliefs by its members (Tichy, 1982). In this case, the Agency has a strong belief in quality services, informed by an indepth clinical assessment; the recognition of both the roots of the Agency as Jewish and the reality of its nonsectarian nature given a desire to respond to the "needs of the city" and the regulations associated with government funding. While the "plan to plan" for this new Division incorporated those beliefs, the internal sociopolitical or marketing process was both time-consuming and critical to the planning task. Understanding that process in the context of organizational change is useful.

The Change Process

Boone and Kurtz (1987) suggest that the most common characteristic of the change process is resistance, caused by:

- ° Lack of clarity - uncertainty resulting from changes that persons do not understand leads to resistance by those effected.
- ° Distortion of information.
- ° Countervailing forces and reward structures.
- ° Levels of participation.
- ° The pace of change.

Zander's (1950) analysis of resistance to change is useful as he writes more specifically about these factors and articulates potential approaches.

1. Resistance can be expected if the nature of the change is not made clear to the people who are going to be influenced by it. Resistance will be prevented to the degree that the changer helps the changees to develop their own understanding of the need for the change.
2. Resistance may be less likely to occur if the group participates in making decisions about how the change should be implemented, what the change should be like, how people might perform in a changed situation, etc.
3. People will more likely act in terms of information they gather themselves than in terms of information gathered by others and delivered to them.
4. Resistance may be expected if the change ignores the already established institutions in the group.
5. Resistance may be expected to the degree that persons have pressure put upon them and decreased to the degree

that the persons have some say in the nature of the change.

Hence, the amount of time and structure of the internal marketing strategies were designed as a constructive alternative to the Agency's use of coercion; procrastination; avoidance and competition as implementation approaches (Morgan, 1986; Cribben, 1981; Brager & Holloway, 1978). Rather, a view toward the superordinate goal, collaboration and, as necessary, compromise were viewed as the ideal. In addition, through the PCC, joint information gathering, problem solving, joint action, education, mild persuasion, bargaining and negotiations within the context of planning were all viewed as acceptable approaches and in fact, were successful. However, as indicated in Chapter 6, internal marketing, below the level of the PCC, was inconsistent and inadequate and will require concerted attention in the very early stages of the implementation process in order to avoid resistance during that phase of program development. This will include training about needs including clinical approaches (e.g. symptom assessment before psychodynamic assessment); the importance of case management, increased use of groups, as well as the basic issue of service to this population. In addition, discussions regarding the integration and linkage of the older adult client and existing Agency clients and systems is critical.

Klein's (1967) caution that the motives of "innovators" are especially apt to be suspect when the planning process has been kept secret up until the time of unveiling the conclusions and actions recommended was heeded. Hence, the distribution of the "plan to plan" and ongoing requests for suggestions were made by the planner. By the time the Division's plan was presented there was no need for its defense, rather, the minimal number of suggestions could be incorporated into the final document. This does not suggest an Agency-wide level of excitement, but rather a willingness of middle-management to join, not lead the "team." In addition, this planner as the newest staff member emphasized that innovation truly begins when one or more individuals perceive that a problem exists and change is desirable and possible (Klein, 1967). Thus credit and "covet" could continually be given to those who identified the original need - in its broadest sense.

The difference between those individuals involved, supportive and enthusiastic about the plan for service delivery and those who approach it with either clear resistance or tentativeness relates to the coalition(s) involved in planning. While Pfeffer and Salancik (1977) posit that structural planning is a rare occurrence and almost never functions as planned, they offer the organizational coalition model as a more realistic locus of planning. Employees, shareholders, managers, suppliers and government agencies all

impinge on the organization and each has a different set of preferences for organizational action along the way. One of the various decision outcomes is who, precisely, becomes involved in the process of influencing the decision. However, as a variety of pragmatic decisions remain to be made with regard to implementation, coalition building will be a priority.

The fact that some participants, as in this case study, are only partially involved in decisions, coupled with imperfect distribution of information, suggests that organizations can become uncoupled - internally and externally. Hence, critical components of the implementation phase are the creation of a Board/Divisional committee, continuation of the PCC as the interdivisional program guide, creation of a clinical and programmatic staff work group and a Division newsletter. Even amongst the PCC members the attractiveness of the "plan to plan" or people's initial support of it was clearly based on exchange theory. Examples relate to, how can this new Division enhance "my" division...will my time expended in key informant interviews be worth my while? Specific examples include the:

- ° Potential for Medicare reimbursement within their Division.
- ° Potential to serve the population for which their Division is responsible - e.g. the chronically mentally ill; HIV+/AIDS.

- ° Potential to serve larger numbers of Jewish clients.
- ° Potential for research initiatives.

In no case was overwhelming need an adequate reason for initial support. However, need competently presented, and the potential for professional agency and client mutual "gain" formed the basis for the PCC's initial interest and ultimate clear support.

Integration of Marketing and Planning Approaches

The identification of important publics, internal marketing approaches and a planning design which included a marketing overlay were critical elements of integrating marketing and planning approaches. It was possible to integrate other components of strategic marketing with social planning including the situational analysis, identification of market niche, and target population. However, some components e.g. location, cost, number of client visits, goals, etc. are program (rather than division) specific. Ongoing planning will clearly incorporate these approaches.

Internal publics, i.e. members of the PCC, key development, public relations and legal staff, finance, regional directors and individuals currently working with older adults had a critical role in the planning effort. First, their historic perspective and current priorities, technical and clinical knowledge and willingness to work with

(or lack of interest in) this population was a critical starting point. Their continued involvement through joint problem identification and resolution, outreach, service prioritizing, participation in focus groups and other forms of data collection were all internal marketing strategies.

Further, the planner's own conscious use of her professional self built on the need for this process to be sociopolitical with the internal publics.

Inter-Agency Exchange

Facilitating communication between local organizations is a classic objective of public health administrators and community organizations to reduce gaps and overlaps in service provision (Levine & White, 1960). Social services exchanges deal with non-competitive facilitating of interdependence where maximal goal achievement by one agency is most likely when other agencies maximize their goals as well (Litwack & Hylton, 1962).

The key informant interview process set the stage for such exchange - whether in the form of information about Medicare billing, jointly sponsored programs or client referrals. One clear goal of the key informant interview process was the beginning of external coalition building - another critical element of a comprehensive marketing and planning strategy.

Interagency relations within the Federation of Jewish Philanthropies network were quite important and began with clarity between CEO's as to this Agency's goal and clear desire for collaboration. As Chapter 8 (Epilogue) describes this has occurred with the two aging-services agencies in this network.

GENERALIZEABILITY

This is a report about a planning endeavor within one complex, metropolitan agency. The problems encountered in this planning process are not atypical in this environment: changing and vague regulations; CON moratoria to contain costs; limited (or no) discussions between various and related departments within the public sector; middle management's view that their day-to-day operations are more critical and perhaps more relevant than planning for the future; (if a clinic has an eight month waiting list for service, why would the staff be interested in serving another segment of the community?), bureaucracy within a large human service organization, and limited governmental funding streams.

Inasmuch as this researcher did not know the Agency in operational detail when the planning proposal was prepared and there were no significant factors that changed its course or basic timeframe, this model as displayed in Table 6 with its related timeframe (Tables 7 and 10) is seemingly replicable.

(Chapter 7 does include a critique and suggested improvements in the process.) In addition, the needs assessment process was functional, useful, presented the Agency in a positive light to the community and provided, most importantly, the requisite data for planning.

With the exception of the literature review (and in this case the orientation to the Agency), the needs assessment stages are overlapping and can be done in the order that is the most convenient and practical for an agency. However, this is not a case study to provide a replicable series of technical approaches. Rather, it is designed to look at the concept, value and feasibility of planning as a technical and dynamic task; the planner as one who is able to "reflect-in-action" and the means by which one can market to an agency's internal publics.

In addition, this is an agency in which new leadership has tried to create an environment in which staff can blossom, develop self-esteem and be excited participants in decision-making (Peters & Waterman, 1982). This change in Agency leadership may also have provided a distinct window of opportunity for both the planning endeavor and outreach to this population. Hence, comprehensive model replicability is not a reasonable expectation nor is a goal.

However, as empowerment by management and a reverence for human effort (Reisman, 1986; Cattabiani & White, 1983) are recognized as legitimate management approaches and marketing

looses its pejorative connotation, it is possible for agencies to plan and to utilize social planning and strategic marketing approaches to inform both growth and down-sizing decisions. This dissertation provides an overview and analysis of both the process and substance of this endeavor and in so doing can be a guide for other agencies.

Practice Principles and Guidelines

This case study demonstrates that:

- ° Planning can realistically be achieved within an agency setting.
- ° The twinned approach of mixed scanning and incrementalism is a framework for such planning endeavors.
- ° The successful planner will have the capacity for flexibility and reflection-in-action.
- ° The internal publics should be viewed as worthy of marketing time and effort beyond that needed to address potential staff resistance and that the sociopolitical components of planning will be most germane and relevant with this constituency.

From the practitioner's perspective a document outlining the "plan-to-plan" guides the process, when disseminated is an indication of the seriousness of the endeavor and sets forth expectations of both the planner and the Agency.

Conceptualizing this as the basis from which the practitioner will begin and "reflect-in-action" is useful if the process of planning is itself to be dynamic.

A series of practice guidelines and principles can be articulated based upon this case study:

1. The idea of planning must be given legitimacy within the organization by the CEO and Board of Directors. From the CEO's perspective this includes, e.g. announcements to (internal) program directors about the value of this effort and the target population, inclusion/recommendation of the planner in inter-agency committees, and encouragement for the planner to represent the Agency with external publics. Planning should be considered as a dynamic process by the CEO.

- a. The CEO must be cognizant that planning is a function with time-delayed benefits; it is also one that requires adequate supports to succeed.

- b. Involvement and support of the governing board is critical; however the specific involvement will be a function of agency culture and practice.

- c. Planning does not end with the production of a report, but rather leads logically into the implementation phase. Relatedly, the planning time frame must be limited; to think of planning in purist's terms distinct from implementation is both simplistic and unrealistic.

d. Public legitimacy of the planning process through public relations efforts set the tone for community response to the planner.

2. Planning within a large multi-site organization must include executive and middle management as well as relevant line staff.

a. Planning is an integral component of executive level staff responsibility.

The creation of a planning unit or as Pfeffer and Salancik (1977) refer to it, an environment scanning unit or long-range planning unit may not solve the problem that planning is a rare occurrence and change almost never occurs as planned. Rather, they suggest that a potentially satisfactory solution is to use an evaluation, reward-incentive system that clearly defines planning and environmental scanning as part of an organization's managers' job. Consequently, planning and implementation are accomplished by the same individual.

b. Whether through existing mechanisms or newly devised work groups, planning cannot only be an executive level function.

c. An internal committee of record should participate in the planning process; when feasible an existing committee or management group provides immediate legitimacy for the project.

3. Planning is both an intellectual and a social process or technomethodological and sociopolitical series of activities. It includes a recognition of internal and external publics.

a. Internal marketing will require at least 50% of the planner's time to address the legitimacy of the population, priorities, stereotypes, ambiguities, and value-systems.

b. Exchange theory and process must be recognized as a component of and often vehicle for the internal marketing effort.

4. Planning and a needs assessment process lend themselves to opportunities to "reflect-in-action." This is essential, in fact, as the process is not predictable; the planner will wish to use both qualitative and quantitative approaches to data collection and to "take advantage" of unplanned opportunities.

5. Consumer input, though time consuming to obtain, is an important part of the framing of the problem and the inclusion of personal realities and related emotion to the planning process.

6. The experienced "planner" brings a historic set of service delivery, academic, governmental and funding contacts which are essential to the effort.

a. That experience also provides a level of sophistication in the reflection process. For example,

using Harrison's (1987) categories of reflection, the experienced planner will rely less on comparison and classification and use of a generic approach and more on heuristic searching.

b. In this case the planner's aging expertise was more important in demonstrating competency than her planning skills. In employing an individual for a related task, the CEO should consider the constellation of skills, contacts and experience and their priority.

7. Planners must create strategies for design and implementation which recognize that the relevance, accuracy, distribution and use of information is essential in planning, especially in a complex environment. However, information is often not used in decision-making and/or program modification because:

- a. There is a unique vocabulary involved.
- b. Often the methods of planners are too sophisticated and not comprehensible to the social work staff.
- c. Physical distance - often the planning is done in a central office hindering the actual dissemination and use of information collected about the environment.

The successful planner will incorporate these realities in the "plan to plan."

8. The planner must be able to assess the host setting's culture and understand the congruence (or lack thereof)

with the planning endeavor, and make appropriate modifications to enable the process to succeed.

9. The planner as Kahn (1969) has noted has significant power over the process with regard to information sought, shared and contemplated. This is both a technical and sociopolitical responsibility.

Chapter 8: Epilogue

As the planning report was approved three months prior to the completion of the writing of this dissertation and the fact that planning and implementation are linked activities, the activities of those three months are of interest. In many ways, these activities parallel the short-term objectives set forth in Chapter 5 of this dissertation.

IMPLEMENTATION OF THE PLANNING DOCUMENT

The following summarizes those activities which have been accomplished during the three month interval from approval of the plan until submittal of this dissertation. These activities include:

Those with a Focus on Internal Publics

1. Selection of a Divisional Chair, review with the Chair of the planning document, identification of 15 potential committee members with confirmation of interest by 8 members to date.
2. Identification of the first geographic area of active outreach including identification of specific clinics involved, involvement of the Public Relations Department in creating a brochure and relevant press release, identification of representatives to relevant interagency

councils in both the geriatric and aging sectors, and scheduling of training on the area identified to be of most critical interest to Agency staff , i.e.

"Psychopharmacology: Special Considerations for the Elderly." This first approach to service design is incremental in nature and responsive to clinic directors.

3. Scheduling of a work group to include PCC, clinic directors, the director of JFLE, to discuss matrix management, including a mechanism by which providers of aging services can regularly meet.

4. Obtaining of Medicare provider numbers for ten mental health clinics; revision of relevant forms; identification of a schema for billing; completion of a "question and answer primer" regarding Medicare to use as an internal training tool.

Service-Focused

1. Completion of grant application for onsite mental health services at seven senior centers and one congregate housing facility under the auspice of Federation of Jewish Philanthropies.

2. Submittal of a grant application for Ryan White governmental funds for the collaboration between a gay and lesbian aging services agency with significant experience in working with the HIV+/AIDS population and this Agency for mental health supports for this population.

3. Submittal of an application to the Robert Wood Johnson Foundation for the development of a social model day program for individuals with early to mid stage cognitive impairments with a community-based organization located in the neighborhood identified as being in greatest need of such service. It is interesting to note that this application required a marketing plan to be submitted as well.

4. Selection of the Geriatric Depression Scale (Yesavage et al., 1983) and the Mini-Mental Status Exam (Folstein, Folstein & McHugh, 1975) as validated, reliable, brief and easy to administer assessment tools for this population.

5. Marketing of "Dependent Care" as one product of the EAP division.

Activities that Focus on External Publics

1. Meeting with the Director of the Area Agency on Aging regarding interest and support for onsite mental health services.

2. Completion of a conference, co-sponsored by three agencies within the Federation of Jewish Philanthropies network, for older adults with adult children with chronic mental illness.

3. Letters sent to all key informants once again thanking them for their cooperation and indicating the key identified unmet mental health needs for this population.

4. Distribution of the Executive Summary of the final report of the plan for the "Division of Mental Health Services for the Elderly" and/or full report to funding sources and governmental agencies. Presentation of same at citywide geriatric mental health committee meetings.

5. Chairing of an interagency task force to identify short and long-term service delivery enhancements for senior Soviet emigres.

6. Meeting with the local Director of Mental Hygiene with regard to the potential waiver of regulations with regard to offsite or satellite services.

7. Identification of a date, conference title, text and keynote speaker for a major conference on mental health and aging with a local school of social work.

It is important to note that the delineation of short, medium and long-range objectives and their approval provides a clear framework for the development of the Division and identifies the tasks to be accomplished. While the reader is no doubt aware, by this time, that this process is a dynamic one, it is noteworthy that so many of the objectives have been accomplished in the first three months following submittal of the plan. This speaks to the value of clarity of vision, practical direction and reflection-in-action.

A P P E N D I C E S

APPENDIX #1

**A Glossary of Terminology and Abbreviations
Relevant to Program Development and
Services for the Aged**

The purpose of this glossary is to provide those workers who may be new to gerontology, an introduction to relevant terminology. For ease of use, the glossary is organized in two parts. Part I is divided into the following sections:

- I. Definitions of Basic Terms Used in Aging
- II. Relevant Legislation
- III. Programs, Services and Service Sites
- IV. Health (including Mental Health)
- V. Elder Abuse
- VI. Aging: The Legal Process and The Mental Health Perspective
- VII. Professional Organizations
- VIII. Abbreviations

Part 2 provides an alphabetical index.

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I. Definitions of Basic Terms Used in Aging

1. AGE AND AGING

Age: One of the stages of life; an advanced stage of life. Also, the latter period of life; the state of being old. Also, to become old; to show the effects of the characteristics of increasing age.

Aged: The state of being old. A person may be defined as being aged on the basis of having reached a specific age -- for example, 65 is often used for purposes of social or legislative policy making.

Ageism: Prejudice against people because they are old; attitudes that devalue older people.

Aging: The changes that occur in persons as they grow older. Some age changes begin at birth and continue until death; other changes begin at maturity and continue until death. Such changes can involve biological, social or psychological changes and can occur at varying rates in different people.

Aging-In: Used most typically to describe a phenomena in housing programs for the aged whereby the average age of a tenant population has increased by a decade, new tenants are the age of those who have "aged-in-place" and service needs have changed.

Elder or Elderly: Generally referring to individuals over age 65.

Functional age: An assessment of age based upon physical or mental performance rather than number of years since birth.

Frail elderly: Elderly person whose physical and emotional abilities and/or social support systems are so reduced that maintaining a household and social contacts is difficult or periodically impossible, without regular assistance from others.

Groups/Categories of Age: Gerontologists generally recognize three age groupings of older persons:

Young-old:	65 - 74 years of age
Mid-old:	75 - 84 years of age
Old-old:	85 years and up

Note: Soviet emigres are considered "old" beginning at age 55 as the life span in the (former) Soviet Union is 10 years less than in the U.S. and women are able to retire at age 55.

2. DEFINITIONS OF GERONTOLOGY AND GERIATRICS

Gerontology: The study of normal aging, including all the sciences which contribute to our understanding of age-related changes of human functioning.

Geriatrics: A branch of medicine that refers to the social, psychological and clinical aspects of disease(s) occurring in old age.

Psychogeriatrics: The treatment and management of mental illness in the elderly.

3. FUNCTIONAL IMPAIRMENT

Activities of Daily Living (ADLs): Basic activities that are undertaken during the course of the day that sustain an individual and permit him/her to function independently. An ADL assessment measures one's ability to:

- * dress
- * bath
- * feed
- * toilet
- * transfer
- * ambulate

and the degree of support, assistance, supervision that may be required.

Adaptive Behavior: Generally speaking, adaptive behavior is any type of behavior that aids an individual in meeting the demands of his or her environment. More specifically, adaptive behavior is measured by the effectiveness and degree to which an individual meets the standards of personal independence and social responsibility appropriate to his/her age and cultural group.

are: The three major criteria of adaptive behavior

- * maturation
- * learning
- * social adjustment

Functional disability: Functional disability is the inability to perform one or more of the basic tasks and procedures necessary for survival in everyday life. It is most typically determined by the number of the activities of daily living (ADLs) in which a person requires direct assistance. Some social services, base the frequency of help provided an aged person on his or her combined score on an ADL assessment instrument.

Instrumental activities of daily living (IADLs): More complex activities that are undertaken during the course of the day that sustain an individual and permit him/her to function independently; An IADL assessment measures the ability to:

- * shop for groceries
- * manage finances
- * perform housework chores
- * prepare meals
- * self-administer medications
- * use local transportation facilities

4. CAREGIVING

Caregiver: The person responsible for the care of the older person. The caregiver may or may not live with the senior adult. Caregiver is usually a family member but may also be a paid worker. (Preferred term to caretaker.)

Caregiver burden: The impact of caregiving responsibilities on the caregiver's physical and mental health, social participation and financial resources.

Elder care: Caregiving to one's relative (or client) who is aging and requires assistance; this term has also begun to be used to define a corporate employee benefit that supports the caregiving role. This may include information and referral; emotional support/counseling for the caregiver; flex time to support caregiving.

Sandwich generation: The generation in the "middle" with caregiving and support responsibilities for both children and parents and occasionally grandchildren and/or grandparents.

II. Relevant Legislation and Government Agencies

1. LEGISLATION

The Social Security Act of 1935: Social Security is a program of economic insurance originally designed to assure that all citizens of the United States will be supplied a minimum base income to support them in their old age.

Initially, the program offered retirement benefits for industrial and commercial workers only. Today coverage has been expanded to include, benefits for the survivors and dependents of the insured workers and disability insurance (SSD).

Contributions to fund Social Security benefits are made by both employers and employees.

The Older Americans Act of 1965: The Older Americans Act is federal legislation that authorizes and encourages federal funding for services to older persons in the United States.

Persons, age 60 and older, are eligible for services provided under Act.

Other Legislation Affecting Older Persons: Other federal legislation for the aged includes Titles XVIII (Medicare), XIX (Medicaid), and XX of the Social Security Act (Social Services programs). Further federal legislation includes the Railroad Retirement Act, and the "Food Stamps" Act.

New York State legislation includes provisions for the Community Services for the Elderly (CSE), Expanded In-Home Services for the Elderly (EISEP), and Recreation for the Elderly.

2. GOVERNMENT AGENCIES

The Administration on Aging (AoA): The Administration on Aging is a federal government agency charged with administering the Older Americans Act.

A branch of the Department of Health and Human Services (HHS), the AoA advocates for the elderly and helps administer federal funds for a network of state and local agencies (AAAs or Area Agencies on Aging) throughout the country. These AAAs in turn provide services such as meal delivery, maintenance of senior centers, and support services.

State Office for the Aging (SOFA): The State Office for the Aging was established under Article 19J of the Executive law of New York State in 1965, as the state unit on aging. SOFA administers and supervises federal, state, and local funding for the senior programs.

Area Agencies on Aging (AAA): In New York State there are 59 Area Agencies on Aging (AAAs). The AAAs generally contract with local service vendors to provide senior citizens with needed goods and services. In New York City, the Department For The Aging (DFTA) is the AAA. In some parts of NYS the county office for the aging is the AAA.

ACTION: is an independent government agency that provides centralized coordination and administration of domestic and international volunteer activities sponsored by the federal government.

Department of Social Services - Protective Services for Adults: The DSS is legally mandated to assist adults in need of protective services without regard to the client's income level. Individuals entitled to assistance include those who:

- are unable to manage their own resources or carry out activities of daily living and
- are unable to protect themselves from neglect or hazardous situations without assistance from others
- have no one available who is willing and able to provide assistance.

Protective services may be necessitated by the action or inaction of another person or because of the adult's own action due to lack of awareness, incompetence or poor health which results in:

- physical or mental injury
- neglect or maltreatment
- failure to receive adequate food, shelter or clothing
- deprivation of entitlements or wasting of resources.

III. Programs, Services and Benefits for Senior Adults

1. BENEFITS AVAILABLE FOR AGING PERSONS, PROGRAMS FOR OLDER ADULTS

Adult Day Care (ADC):

Adult day care allows older and disabled persons who would theoretically otherwise be in a nursing home to receive care in the community while remaining at home. Most programs provide services for those who do not need 24-hour care but need more care than homemaker services offer. Adult day care covers a wide range of models from intensive programs that closely mirror day hospitals (usually called adult day health care) to social day care programs.

Through adult day care older adults are provided a variety of services including medically related services (provided in medical day care programs also known as adult day health care programs) and personal/custodial services (provided in some social day care programs); often programs combine these two types of care. Services may be provided in a freestanding center or within a sponsoring institution, such as a hospital, nursing home, or community agency. Adult day care centers provide assistance to clients for a portion of the day. There are more than 2,000 ADC programs nationally. Clients typically attend 2-3 days/week.

Adult Foster/Family Care Programs:

Place elderly persons in suitable homes with foster families who will be caregivers for them.

Care Management: A service designed to assess the needs of an elderly person, develop a plan to meet these needs, link the person with the appropriate service provider, and then monitor the implementation of services.

Funding: The Older Americans Act, New York State Community Services for the Elderly (CSE), New York State Expanded In-Home Services for the Elderly (EISEP), Recreation for the Elderly, HRA.

Administered by: Area Agency on Aging, HRA, Department of Social Services.

Certified Home Health Agency (CHHA):

A Medicare supported program designed to provide short-term nursing, rehabilitative therapy and/or home health aide services following an acute illness.

Congregate Housing Programs:

Shared living arrangements intended for elderly people who no longer wish to or are able to live alone. This includes HUD (Housing and Urban Development) supported apartments, enriched housing (housing with services), group homes, board and care homes, etc.

Congregate, Homebound, and Weekend and Holiday Meals:

A program that supplies meals in group or homebound settings.

Funding: OAA, HRA, The Supplemental Nutritional Assistance Program (SNAP).

Administered by: Area Agency on Aging and/or The New York City Department for the Aging and/or Human Resource Administration (HRA).

Continuing Care Retirement Communities (CCRCs):

Residential settings for older adults which combine financing and delivery of long-term care services and provide some form of catastrophic insurance for noncovered services. Residents pay a monthly charge and initial entry or purchase (of apartment) fee. Housing, social and recreational services, and medical and preventive services are provided on the community's "campus." Also included may be annual physicals, emergency response systems, therapies, hospitalization coverage, prescriptions, and social services.

This model is primarily accessible to the most affluent elders since entrance and maintenance fees are high.

In New York State, CCRCs were legislatively available for development beginning in 1990. To date, however, there are no CCRCs in the State.

CORF (Comprehensive Outpatient Rehabilitation Facility):

A Medicare supported program, designed to provide short-term restorative physical, occupational, speech

and/or psychiatric treatment in an outpatient setting. In New York State, all CORFs must also be licensed as a Diagnostic and Treatment Center (DTC)

Counseling/Crisis Intervention: Professional counseling and support offered to eligible seniors in times of crisis at senior citizens, medical, and psychiatric facilities.

Funding: Medicaid, Medicare, private Medigap insurance, private pay.

Administered by: The sponsoring agency.

Elder Law Projects:

Provide legal advice and representation to persons aged 60 and over. The services provided by Elder Law Projects are mandated by the Older Americans Act, and funded in part through its federal budget authorization.

Emergency Response Systems:

Communications systems also often referred to as lifelines or Personal Emergency Response Systems (PERS). They provide the older or disabled person living at home with a 24-hour link to police or rescue squads and a medical facility. The system works through a transmitter, carried by the user, and a receiver connected to the individual's home. If the user pushes a button on the transmitter, the phone receiver automatically dials an emergency number. The system can also be set so that it will initiate an emergency response if the user has not used the telephone or pushed a designated button for a set period of time. This is typically privately accessed although it is a wavered service within the Lombardi programs.

Food Stamps: Coupons of exchange which are provided to eligible elderly (among others) and which can be used in lieu of cash for buying groceries, acquiring home-delivered meals, and for purchasing a meal in certain senior centers and restaurants.

Funding: General federal revenues.

Administered by: The United States Department of Agriculture (USDA) through state and local welfare agencies.

Foster Grandparents: A program that offers eligible elderly persons a small stipend for performing

one-on-one care of institutionalized children or children with special/exceptional needs.

Funding: The State Office for the Aging and ACTION.

Administered by: Designated agencies.

Home Energy Assistance Program (HEAP): HEAP helps defray the costs of monthly heating and utility bills for eligible elderly (among others).

Funding: Federal funds.

Administered by: Local utility companies in conjunction with the Area Agency on Aging, and other local agencies.

Home Health Care: Provides homemaking and personal care by trained homemakers and home attendants.

Funding: Federal, state, and local government revenues and/or private funds.

Administered by: Vendor agencies designated by Medicare and Medicaid programs.

Homemaking, Housekeeping, Chores: A group of homemaking services made available for eligible aged persons in need of domestic aid.

Funding: Title XIX (Medicaid) of the Social Security Act for HRA and EISEP for DFTA.

Administered by: The Human Resource Administration(HRA) and by DFTA.

Hospice Services:

This is care for the terminally ill, in the medical, home setting, freestanding sites and institutionally sponsored settings. Emphasis is on relief of pain and emotional support for the client and his/her family. Medicare support is available.

Information and Referral: Up-to-date information provided to interested parties concerning appropriate social services and entitlements.

Funding: Older American Act, private funds, HRA.

Administered by: Sponsoring agencies.

Long-Term Home Health Care:

Also known as The Lombardy Program and Nursing Home Without Walls is a New York State program reimbursed via Medicaid or private pay. An individual must be medically eligible for nursing home care and have an interested and available local family member for back-up. An array of services are available including nursing services, home care workers, rehabilitation therapists, social work and care management.

Medicaid (Title XIX of the Social Security Act): A large-scale government program that offers medical assistance of various kinds to the eligible poor. Medicaid pays for a full range of health care costs (including fees not covered by Medicare) such as doctor bills, dental fees, custodial costs, health related and community home health care, transportation for Medicaid reimbursed services, etc.

Funding: Federal, state and local revenues.

Administered by: The Department of Social Services' state, local, and county welfare offices, in accordance with federal guidelines, HRA in NYC.

Medicare (Title XVIII of the Social Security Act): A large-scale government program of health insurance designed to provide medical aid for the elderly and disabled.

Funding: Federal taxes and self pay.

Administered by: The Department of Health and Human Services.

Medicare/Part A: Medicare part A helps pay acute care hospital costs, some home care costs, and covers the costs of skilled nursing facilities (SNF) (includes a deductible).

Funding: Social Security payroll taxes (or self-pay monthly premiums if the person is not eligible for Social Security).

Administered by: Social Security Administration (SSA) and Health Care Financing Administration (HCFA), both of which are part of the Department of Health and Human Services.

Medicare/Part B: Covers the costs of a physician's services in hospital and out, plus fees for hospital outpatient services. The contribution for Medicare part B is made in the form of a premium paid by elderly participants; it is not deducted from payroll taxes during the working years. Recent changes in the law provide reimbursement for mental health services provided by qualified social workers and psychologists (as defined by law).

Funding: Since the government keeps the payments for Medicare part B extremely low (these payments cover only 25 percent of the actual costs) funding for this program is actually a mixture of social insurance and a government subsidy.

Administered by: Social Security Administration and Health Care Financing Administration.

New York State Elderly Pharmaceutical Insurance Coverage (EPIC): A program that assists in lowering prescription drug costs to the elderly by reimbursing them for a portion of medication costs.

Funding: New York State general revenues
Administered by: New York State Office for Aging.

NORC: Naturally occurring retirement community; that is an apartment complex or cluster where the residents have "aged-in"; usually used in the context of demonstrating an area needing services.

On Lok Senior Health Services:

Originated in the Chinatown area of San Francisco, this model is directed toward the long-term care needs of a frail, elderly population. An interdisciplinary team provides both care management and health care services. Financing is on a capitated basis, i.e. a set reimbursement rate/client/month v. fee-for-service. Presently, there are a number of On-Lok look alike projects, including one at Beth Abraham Hospital (Bronx).

Public Assistance (PA): A service that provides income for persons unable to work or to earn an income. PA provides income (or interim income before SS, SSI, pension benefits become available), automatic Medicaid, and emergency cash.

Funding: Federal, state, and local revenues.

Administered by: HRA

Public Housing: A series of programs that provide affordable shelter for urban and rural elderly renters and homeowners through financing and construction of rental units and providing rehabilitation assistance for existing dwellings. HUD subsidized housing programs-known as Section 8 housing subsidize rent for low income elders so that no more than 30% of their monthly income is used for rent.

Funding: HUD, USDA (rural), state and city assisted.

Administered by: Public housing authorities operating under state and local laws.

Respite Care:

Respite care is intended to give occasional, temporary relief to caregivers. The disabled client may receive a combination of homemaker, personal assistance, and chore services. When delivered outside the home, respite care may be provided in a freestanding day care center or within a sponsoring institution, such as a hospital, nursing home, or community agency.

Legislation has been drafted in New York State to permit nursing homes to expand their bed capacity by 2 beds/home to make residential respite care more accessible. Reimbursement is consistent with the funding streams of the site, and via small local grants (e.g. Alzheimer's Association of Westchester).

Reverse Mortgage Annuity: A program that allows an elderly home or apartment owner to borrow from a lending institution against the real estate equity of his/her residence for a determinant period of time.

Funding: Participating banks.

Administered by: Participating banks.

Senior Centers: Programs which offer a range of supportive services on a local community level for the elderly.

Funding: The Older Americans Act, Title XX, local government revenues, and private funds.

Administered by: Area Agency on Aging (AAA), private sponsoring agencies, or a combination of the above.

Senior Citizen Rent Increase Exemption (SCRIE): A program, presently instituted in three New York State cities (Rochester, New York, and Yonkers) to induce landlords to freeze present rent levels for eligible senior citizens. In return landlords are compensated with a reduction in real estate taxes.

Funding: State, local, and general revenues.

Administered by: Division of Rent Policy.
Mitchell-LAMA, through management.

Senior Community Services Employment Program: A program which provides part-time jobs for persons 55 years and over and who are below 125% of the poverty level.

Funding: Title V of the Older Americans Act.

Administered by: A local AAA.

Senior Companion Program: A program in New York State in which elderly persons are paid a small, regular stipend to provide one-on-one personal care to adults with special and/or exceptional needs.

Funding: OMRDD.

Administered by: OMRDD District Offices and designated vendor agencies under contract with OMRDD.

Skilled Nursing Facility (SNF): A facility that provides skilled nursing care on a 24 hour-a-day basis to incapacitated persons whose needs for skilled nursing care are quantified through the PRI and corroborated by a physician's certificate of need.

Funding: A mixture of government and private funds.

Administered by: The New York State Department of Health.

Social Security: A long-standing federal program designed to afford American workers economic protection in their old age. Income from Social Security is provided for all insured workers, as well as (their spouses, children, and surviving parents).

In certain cases eligibility and pay scale are based on an individual's age, and earning level and number of years of employment.

Funding: Compulsory contributions from employees, employers, and the self-employed.

Administered by: The federal government through the Social Security Administration (SSA) and its local offices.

Service Corps of Retired Executives (SCORE):

As SCORE volunteers, retired business people help owners of small businesses or community organizations who are having problems with management. Since 1965, SCORE volunteers have helped more than 175,000 enterprises succeed. Volunteers may be reimbursed for out-of-pocket expenses.

Social Health Maintenance Organization (S/HMO) Services:

Several S/HMOs were funded by the federal government in 1982 as demonstration projects to assess the effectiveness of offering a broad range of health, social, and long-term care services to Medicare beneficiaries through an HMO-like (capitated) financing system. The S/HMO concept combines the care management and social support concept with capitated payment.

A major goal of the S/HMO approach to long-term care is to bring the service provider and funding source together under one umbrella. Services generally include the standard medical services offered by HMOs, as well as home health care, homemaker, and chore services. These care-managed systems have grown within Medicare and Medicaid programs but tend to enroll elders with slightly better health status. In New York City, Metropolitan Jewish Geriatric Center sponsors a S/HMO called Elderplan.

Supplemental Security Income (SSI): A national minimum income supplement which is provided for the aged, blind, and disabled. SSI income is designed to be combined with Social Security, pensions, etc.

Funding: Compulsory contributions from employees and government employers (i.e., general tax revenues).

Administered by: The federal government through the Social Security Administration (SSA) and its local offices.

Telephone Reassurance:

This is a community program in which daily telephone calls are made to "check in" with elderly and disabled persons living alone. Telephone reassurance programs typically are staffed by volunteers. In rural areas, mail carriers often provide a similar service.

Transportation Services: Services which provide free or reduced fare transportation for the elderly by car, bus, subway, van, limousine, reimbursed taxi service, etc. The form of service varies from provision of bus/subway tokens (NYC), to transportation to/from senior centers, adult day health programs, etc.

Funding: Various sources.

Administered by: Area Agency on Aging and/or local transportation agencies.

2. PROGRAM ASSESSMENT AND REIMBURSEMENT

Assessment Instruments to Determine Eligibility for Service(s):

PRI (Patient Review Instrument): Determines eligibility for nursing home care in New York State. Via a scoring mechanism defines which one of 16 categories of care needs (Resource Utilization Groups) a potential (or current) nursing home resident requires. The Resource Utilization Groups have a numeric score attached which when averaged for all the residents of a facility produces a case mix index score for the facility which is linked to reimbursement rates.

MDS+ (Minimum Data Set Plus): comprehensively assesses a nursing home resident's needs and strengths as the basis for careplanning. The MDS is a federal requirement; the "plus" is a New York State enhancement. Theoretically designed to provide additional, useful assessment information.

MII-Q: assesses the need for Medicaid supported home attendant services.

DMS-1: (formerly used to assess the eligibility for and care needs of nursing home residents) is now used to determine eligibility for Long Term Home Health Care Programs.

RAI (Registrant Assessment Instrument): The assessment tool required in New York State to determine adult day health care program eligibility and care needs.

IV. Health (Including Mental Health)

Acute: A term describing a sudden, sharp pain or a physical condition with a specific onset and limited duration (as opposed to chronic).

Adaptive Equipment: Devices such as a hearing aid or walker that allow an individual to regain use of a body part or to perform a body function.

Affective disorders: Disorders characterized by moods, feelings, and emotions disproportionate to the objective situation and tending to disruptively pervade many aspects of behavior. The most common affective disorders among the elderly are chronic anxiety and depression, with resulting disturbances in thought processes and normal functioning.

Aphasia: Inability to use or understand spoken or written language.

- a. Receptive Aphasia -Inability to receive messages.
- b. Expressive Aphasia -Inability to express oneself.

Apraxia: Inability to carry out purposeful movements in the absence of paralysis or other sensory or motor impairments.

Ataxia: Muscular in coordination especially that manifested when voluntary muscular movements are attempted.

Decubitus Ulcer: A pressure sore or ulcer which may be the result of prolonged inactivity, bony prominences, poor nutrition, poor preventive skin care.

Dementia: Gradual and lasting deterioration of intellectual powers and mental effectiveness. (Preferable term to senility.)

Primary degenerative dementia: Most typically associated with Alzheimer's and Pick's disease have an insidious onset and gradually progressive course for which all other specific causes have been excluded by the history, physical examination and laboratory tests.

In contrast, Multi-Infarct Dementia (MID) is a stepwise deterioration in intellectual functioning, with typical abrupt onset. Vascular disease is always presumed to be present and responsible.

Edema: The accumulation of fluid in the tissues.
Abnormal swelling of a part of the body.

IV Therapies: Intravenous therapies. Refers to nutrition and medication given through intravenous tubes.

Parkinson's disease: A condition in which the ganglia at the base of the cerebrum degenerate, causing a syndrome that includes muscle rigidity, stiff gait, vocal changes, and tremor.

Prosthesis: An artificial replacement for a missing part of the body.

ROM: Range of motion.

- a. PROM -Passive range of motion. The range limits of movement in a joint possible when manipulated by the therapist.
- b. AROM -Active range of motion. The range of motion possible when an extremity is moved by the patient without assistance from the unaffected extremities.

Senescence: The aging process.

Stroke: A sudden clotting in or rupture of one of the blood vessels that lead to the brain.

V. Elder Abuse Terminology

Abuse: The term abuse includes: physical abuse, psychological abuse, neglect and financial exploitation.

Physical Abuse: Willful, direct infliction of physical pain or injury.

Psychological Abuse: The infliction of mental anguish. Any action intended to imposing emotional pain including: humiliation; intimidation; isolation; verbal assaults.

Neglect: An act of omission which results in harm to the older person. Withholding of personal and hygiene care, nutrition, medical attention.

Financial Exploitation: Any situation involving the dishonest use of an older person's resources, such as money or property.

Protective Service Agency (PSA): Responsible in New York for the evaluation of an individual's cognitive and/or functional competence, if the home environment and/or family system within the home poses a threat and development of an alternative, safe living and care plan.

Protective Services must accept all referrals made within normal working hours. An investigation and a visit must each be made within a specific time after referral. In serving persons found to be in need, PSA may:

- counsel the client, his family, or other responsible person (e.g., representative payee.)
- provide homemaker and housekeeper/chore service
- secure alternate living arrangements
- arrange community social services, medical or psychiatric care, or legal assistance to secure rights and entitlements.
- initiate legal proceedings to protect and provide service for client e.g., conservatorship.

(In the text that follows "he" and "his" are intended to be gender neutral and are so used for the sake of brevity.)

VI. Aging: The Legal Process and the Mental Health Perspective

As the elderly client develops functional disabilities, there become available a variety of legal options designed to assist him. Broadly speaking, the degree of disability will determine the form of legal intervention deemed appropriate. The law favors the least intrusive intervention possible given the extent of the client's dysfunction. In so doing, the law aims to strike a balance between the individual's need for assistance or protection and his basic right to self-determination.

Striking such a balance is equally important from a psychological perspective. The mental health worker aims to help while preserving the autonomy of the older adult and maximizing independence. In the service of autonomy and independence, each legal option available to the elderly can be evaluated in terms of its impact upon the decision making process and authority of the individual. Some legal devices allow an individual to engage in a form of legal self-help and augment the individual's exercise of choice (e.g., the health care proxy). Other legal interventions to assist or protect the individual substantially reduce his decision making authority, potentially contravene his wishes, or may prove to be emotionally/socially distressing or disruptive (e.g., the appointment of a committee for an incompetent). Clearly, a determination that an older adult needs legally structured assistance in the management of personal or financial matters gives rise to important issues of both a clinical and ethical nature.

In considering the need for legal intervention to assist the older adult client, the mental health worker might wish to consider the following questions as they relate to the case at hand. These questions pertain to the practical and ethical implications of contravening the wishes or decision-making authority of the older adult. They are posed to suggest the multitude of parties, interests, conflicts and professional dilemmas encountered in providing service to the elderly.

- When does an individual have the right to make a decision someone else (therapist or physician or family member) may consider wrong?
- What are the consequences of non-intervention in a client's decision-making process?
- Does the client understand the nature and effect of the decision he is making? Does he understand the alternatives and their potential benefits and risks?

- Are his actions truly voluntary rather than the result of uncontrollable impulse or duress?
- Is the client acting for the convenience of others?
- Whose interests are being affected by the decisions and actions of the older adult?
- Can the mental health worker simultaneously serve the elderly client and the interests of the family? Where conflicting interests exist, can they be reconciled?
- Should the personal choice or legal rights of the older adult ever be restricted to accommodate the needs of other family members? To accommodate security and safety concerns? To save money?
- Does the client want the proffered assistance, therapeutic, legal or other? Or does he oppose any third party intervention on his behalf?
- Is his mental/physical status so deteriorated that he cannot decide what assistance he wants or needs?
- Is he capable of making some kinds of decisions but not others? If so, can a social service/legal plan be formulated that provides for assistance/intervention which is decision-specific?
- Is he so incapacitated that others should be asked to act for him regardless of his wishes?
- When does the client's need for help outweigh his right to be left alone?
- Should a court or government agency be asked to assume responsibility for a client's personal or financial well-being?
- Does the mental health worker owe a duty of disclosure to the court, to a governmental agency or other third party concerned with the status of an elderly client? What about the client's right to privacy?
- To whom does the mental health worker owe a duty of confidentiality? To the client, to a family member concerned with the client's well-being?
- When should the human right to self-determination and the legal rights attendant thereto be curtailed for the client's own protection?

A. General Terms

Mental Capacity/Incapacity

As a legal term, mental capacity generally refers to the ability to understand the nature and the effect of the act in which one is engaged. Mental capacity may, more specifically, be a measure of intelligence, comprehension, memory, judgment, intent or even volition, depending upon the facts at issue. Mental capacity, however measured, is that minimal reasoning ability and clarity of purpose which an individual must possess in order to act in a legally binding fashion or to be held legally accountable for his actions.

An individual exhibiting mental dysfunction may nonetheless be capable of creating legal obligations which bind himself and others, of incurring liability for tortious harm, or of bearing criminal responsibility. Inquiry into the individual's mental state, its relevance and effect, must be separately made with regard to each legally significant act.

Consider that an elderly client, albeit disorganized and disoriented at times, may nonetheless be held to have knowingly signed a lease. Even a client with delusional ideation may be bound by the terms of a contract entered into without regard to the delusion. Similarly, a person in need of a conservator may draft a valid will if he understands its import and its significance to his heirs. For that matter, he may be found capable of intentionally assaulting a passerby or trespassing on his neighbor's property. In each instance, the legal sufficiency of mental capacity will be independently evaluated.

It follows, therefore, that if a court finds mental incapacity in one instance, the subject individual retains capacity in other areas. He is not legally disqualified, as it were, from exercising other rights; nor is he excused from being held accountable for other consequences.

In summary, it may be helpful for the mental health professional to bear in mind that the mere existence of mental dysfunction is not legally determinative of the issue of mental incapacity. A client's functional disability should not, then, be equated with a notion of legal incapacity. Nor should a legal finding of incapacity in one instance be confused with the more comprehensive legal determination of incompetence (infra).

Incompetence

Incompetence, as defined in the Mental Hygiene Law,

refers to a determination made by a court of competent jurisdiction that a person cannot manage himself or his affairs because of age, alcohol abuse, mental illness or other reason (Mental Hygiene Law Sec. 78.01). Unless a person is so adjudged by the court, he is not legally incompetent, regardless of the bizarre nature of his thoughts or behavior. Even a psychiatric patient who has been involuntarily hospitalized is not deemed to be incompetent by virtue of his commitment.

A judicial determination of incompetence has extensive legal, financial, social and psychological ramifications. A committee is appointed to assume control of the incompetent's financial and/or personal affairs; many of the incompetent's individual civil rights are effectively suspended; the incompetent may be stigmatized and may suffer loss of self-esteem as one who has been judicially found to be comprehensively incapable of making decisions.

Given the severity of the consequences arising from a finding of incompetence and appointment of a committee, there exists under New York statute a preference for the appointment of a conservator rather than a committee (Mental Hygiene Law Sec. 78.02). Appointment of a conservator requires a finding of only "substantial impairment" (Mental Hygiene Law Sec. 77.01) and generally has a more limited effect upon legal rights and personal freedom of choice than does the appointment of a committee. Accordingly, when a choice exists between conservator or committee, the conservator is favored as the "least restrictive alternative" available under law.

B. Legal Options

Representative Payee (of Social Security or Supplemental Security Income)

When a recipient of Social Security or Supplemental Security Income (also called a "beneficiary") experiences difficulty in managing his benefits, the Social Security Administration may appoint a representative payee to receive the beneficiary's check and to provide the beneficiary with financial management assistance. A representative payee may be appointed upon a determination by the Social Security Administration that: 1) the beneficiary is unable to manage or direct the management of his benefit and 2) the beneficiary's interests will be served by representative rather than direct payment. Upon such determination and the appointment of the representative payee, the benefits are mailed to the payee to be spent by him for the beneficiary's food, shelter, clothing, medical care and personal items.

In choosing the payee, the Social Security Administration will consider the proposed payee's demonstrated interest, caretaking ability, and relationship with the beneficiary (familial, custodial, legal or social.) The payee may be a person, agency, or institution. As a general matter, the Social Security Administration is obliged to identify potential conflict of interest on the part of the proposed payee. (As a practical matter, an individual with a personal interest in the beneficiary's funds, i.e. an heir, may have a conflict in regard to spending freely on behalf of the beneficiary. The conflict may not even be consciously perceived by such a proposed payee. A mental health worker might certainly wish to remain sensitive to the possible existence of a conflict of interest.)

In making the determination of the need for an appointment, the Social Security Administration will consider medical evidence regarding the beneficiary's health, chance of recovery from illness, and the ability to manage finances. The Social Security Administration will also consider statements from friends and relatives familiar with the beneficiary's financial management abilities. A representative payee must be appointed for a legally incompetent beneficiary or recipient of supplemental security income who is disabled as a result of drug addiction or alcoholism.

A beneficiary is entitled to written notice of the appointment of a representative payee. It is his right to review the evidence before the Social Security Administration. He also has a right to appeal the determination that a payee is needed and the specific designation of the named payee. The appointment can be terminated when the Social Security Administration is provided with sufficient evidence that the beneficiary has regained the ability to manage his benefit.

Conservatorship: Conservatee & Conservator

A conservatee, as defined under the Mental Hygiene Law (Sec. 77.01), is a person found by a court, by reason of age, illness, infirmity, mental weakness, addiction or other cause to have "suffered substantial impairment of his ability to care for his property" or to have "become unable to provide for himself or others dependent upon him for support." Such a finding results in a judicial order appointing a conservator.

The appointment can be made even if it is contrary to the wishes and over the objections of the proposed conservatee. In those cases where the proposed conservatee does choose to nominate a person to serve as conservator, the court is not bound by the conservatee's

selection.

The conservatee does, however, retain rights in many areas not specifically related to the financial management issues before the court. As provided by statute, "A conservatee shall not be deprived of any civil right solely by reason of the appointment of a conservator...." (Mental Hygiene Law Sec. 77.25). Additionally, the finding of impairment which can lead to the appointment of a conservator is not necessarily dispositive of other issues involving the mental capacity of the conservatee. For example, a conservatee may dispose of property by will if he knows the nature and extent of his property and who it is that would naturally be considered his heirs. Nor may the appointment of a conservator be considered as evidence of incompetence.

A conservator is a "relative or friend" who is appointed by the court to control and manage the property and financial affairs of the conservatee. "Friend" is defined as including "a corporate body, social services official, or public agency authorized to act in such capacity which has a concern for the financial and personal well-being of the proposed conservatee." (Mental Hygiene Law Sec. 77.03).

The judicial order appointing the conservator specifies the extent of the property to be controlled. In this way, the remedy is tailored to the specific fact situation presented to the court. The conservator is obliged to first use the conservatee's funds for the support of the conservatee. The conservatee may be given an allowance to be spent without supervision. Once the conservatee is provided for, monies may be spent for support of the conservatee's legal dependents.

Although the Mental Hygiene Law does not expressly give the conservator control over the personal affairs of the conservatee, the order of appointment must contain a plan which in part provides for the preservation of the conservatee's "personal well-being, including the provision of necessary personal and social protective services." (Mental Hygiene Law Sec. 77.19). Accordingly, some courts have given conservators authority in regard to personal affairs.

The appointment of the conservator may be for a specified term or an indefinite period of time. The conservator is required to make an annual accounting and inform the court of the present status of and future plan for the conservator. If the court is satisfied there is no longer a need for the conservator, the conservator is discharged when the conservatee regains the ability to manage his property, dies, or ceases to have assets. If

the conservatee is declared incompetent, the conservator will be replaced by a committee appointed to perform similar and additional functions. (It should be remembered, however, that there is a preference under New York law for the appointment of a conservator, rather than a committee. See entry on incompetence, supra p.24 for discussion of conservatorship as least restrictive alternative.)

Committee

Upon a judicial finding of incompetence, the court appoints a committee to assume responsibility for and control of the personal and/or financial affairs of the incompetent individual. (Mental Hygiene Law Sec. 78.01). A committee is not usually made up of multiple appointees as the name would imply, but is, more typically, one individual. While the court is permitted to appoint a committee of the person and a committee of the property, one committee may, and usually does, perform both functions. If the court determines that the committee is no longer needed, it is discharged by the court when the incompetent regains competency, dies, or ceases to have assets.

The committee is the mechanism employed by the court in exercising its jurisdiction over "the custody of a person and his property if he is incompetent." (Mental Hygiene Law Sec. 78.01) The committee is directed to fulfill its financial responsibility by using the incompetent's assets for the safekeeping, support, maintenance and education of the incompetent and his family (Mental Hygiene Law Sec. 78.01). Additionally, the Mental Hygiene Law expressly empowers the court to authorize the committee (in contrast to the conservator) to act for the incompetent in the personal realm. Accordingly, decisions regarding non-financial matters such as residence, involuntary placement and medical treatment are clearly within the scope of the committee's authority.

The proceeding for the appointment of a committee is, therefore, one in which extremely intrusive legal intervention is sought. The individual's decision-making authority, his basic human right to self-determination, and his attendant legal rights are very much at stake. Accordingly, a petition seeking the appointment of a committee must explain why the appointment of a conservator, a less restrictive alternative, would not be appropriate (Mental Hygiene Law Sec. 78.03). (See entry on incompetence supra p.23 for discussion of legal preference for conservatorship.) The court will deny the petition for the appointment of a committee if it finds that a conservatorship would be suitable.

Guardian ad litem

A guardian ad litem is an individual appointed by the court to represent the interests of a person who is the subject of, or affected by the outcome of, a legal proceeding. For example, the court may appoint a guardian ad litem to represent the interests of an individual who is the subject of a conservatorship or incompetency proceeding. Under certain circumstances which occasion concern for adequate representation of the interests of the proposed conservatee or alleged incompetent, the court must make such an appointment.

The guardian ad litem does not necessarily urge the court to accede to the wishes of the proposed conservatee or alleged incompetent. The role of the guardian ad litem is to investigate the factual situation and available options and then advise the court as to the need for the appointment of a conservator/committee.

Power of Attorney and Durable Power of Attorney

A power of attorney is a document authorizing another to act on behalf or in place of oneself. The person who creates the power of attorney by signing the document is called the "principal." Generally speaking, any adult who understands the nature and significance of what he is doing can act as principal. The person to whom authority is delegated is called the "agent." (The agent may also be called the "attorney in fact," but the use of that term does not mean that he need be a lawyer.) Contained in the power of attorney is the statement of what the principal authorizes the agent to do.

Unless otherwise specified in the document, the agent's authority becomes effective upon the principal's signing of the document. The document may, however, provide that the power is to take effect only upon the occurrence of a specified future event.

As a general matter, the principal can revoke the agent's authority whenever the principal wishes. The document itself may provide that the power is to terminate upon the occurrence of a specific happening. Certain future occurrences may terminate the power as a matter of law. One such occurrence is the subsequent mental disability of the principal.

As a theoretical matter, the principal is assumed always to have a right of supervision over the agent. If his ability to exercise such a right is compromised by mental disability, the continuing authority of his agent may be called into question. The agent's continuing authority may be challenged in the normal course of business and then in a judicial proceeding. Depending upon the nature of the principal's disability and the facts of the transaction at issue, a court might deem the agent's authority to be continued, suspended, or revoked. The interests of the principal, as well as issues of notice of the disability and fairness to third parties, will be considered.

If a principal wishes to discourage such future challenges to the authority of his agent, he may create what is known as a "durable power of attorney." For a power to be "durable," the principal must state therein that "This power of attorney shall not be affected by the subsequent disability or incompetence of the principal or words of similar import....." (General Obligations Law Sec. 5-1601).

It is advantageous to use a durable power of attorney because the principal is then better enabled to plan for a time when his mental faculties may deteriorate. For example, an older adult who needs assistance with the management of his affairs might find it helpful to execute a power of attorney. Typically, he might authorize a trusted agent to manage a bank account, obtain public benefits, receive income or sell property. If a durable power is created, that same agent, chosen by the principal, can continue to provide assistance, even at a future time when the principal has lost the ability, legal capacity or competence to authorize such assistance. In the event a conservator or committee is appointed, the agent will then account to the conservator or committee rather than the principal. (The conservator or committee has the same power the principal would have had to terminate the power of attorney.)

Health Care Proxy and Living Will

A health care proxy is a document in which an individual ("the principal") protects his health care wishes by appointing someone he trusts ("the health care agent") to make treatment decisions on his behalf in the event he is no longer able to do so. The agent's authority becomes effective when the attending physician makes a determination that the principal is not capable of making health care decisions on his own.

Generally speaking, unless the agent is restricted by the terms of the proxy, the agent can make any decision that the principal could have made. The agent's authority extends to decisions about the withholding of life-sustaining measures. His authority to refuse artificial nutrition or hydration (nourishment or water provided through a tube) is, however, conditional. Unless the agent has reasonable knowledge of the principal's wishes in this regard, as expressed in the proxy or otherwise made known to the agent, the agent cannot refuse said nutrition or hydration. A person wishing to give his agent authority to refuse artificial nutrition and hydration can explicitly do so in the proxy.

By the same token, a principal may expressly limit the authority of his agent by stating the desired limitations in the proxy.

Any competent adult may execute a proxy by signing same before two witnesses. He may designate as agent any adult over the age of eighteen although there are special restrictions on the designation of an employee of a facility in which the principal is a patient or a resident. If the principal designates his physician as agent, the physician is precluded from acting as both attending physician and agent once his authority as agent becomes effective.

In New York State, the appointment of a health care agent is authorized by statute (Public Health Law Article 29C). The proxy need not contain a statement of the principal's wishes regarding specific treatments for the appointment to be valid.

In contrast to the health care proxy, a so-called "living will" is a document primarily designed to provide specific information and guidance regarding an individual's treatment choices. An agent, or family members and physicians in the absence of an agent, can look to the living will in attempting to discern the wishes of an incapacitated patient. New York courts have accepted living wills as evidence of such a patient's wishes. Problems of interpretation may, of course, arise if a patient's wishes are not consistently expressed in both proxy and living will, where both have been executed.

The health care proxy and living will are not to be viewed merely as legally acceptable devices used to authorize the termination of life by the refusal of life-sustaining measures. In fact, a proxy may explicitly prohibit an agent from refusing such measures, and a living will may expressly declare an individual's desire to benefit from any and all life-saving treatment. Both documents can thus be viewed as a positive exercise of the

individual's decision-making authority and his right to self-determination.

VII. Professional Organizations

Organizations:

American Association for Retired Persons (AARP): An organization for individuals 50+ providing insurance benefits, publications and lobbying.

The American Association of Homes for the Aged (AAHA): AAHA is a national association of over 3,000 not-for-profit community-based nursing homes, continuing care retirement communities, homes for the aging, and community service organizations.

American Geriatrics Society (AGA): Physicians (primarily) membership organization.

The Gerontological Society of America (GSA): A national organization of professionals in aging with a strong interest in research and program innovation.

The National HomeCaring Council: The National HomeCaring Council was funded in 1988 to develop a national certification program for homemakers, home health aides, and other professionals providing services in a client's home. The standards that have recently been revised are primarily structural in nature and include the requirement of a quality assurance committee, written policies, personnel qualifications, training, supervision, and in-home patient assessment. Standards on clients rights and the process of case management were added in 1988.

The National Hospice Organization (NHO): The National Hospice Association adopted standards for hospice care in 1978 as a means of focusing attention on the need for quality of care. The organization then lobbied Congress to provide funding for such care. In 1979, the Health Care Financing Administration authorized the funding of 26 demonstration programs; in 1982, the Tax Equity and Fiscal Responsibility Act was amended to provide hospice benefits to those that were Medicare eligible. In 1987, the NHO reported that 24 states and the District of Columbia had adopted formal licensure laws or regulations.

National Institute on Adult Day Care: In 1979, the National Institute on Adult Day Care (affiliated with the National Council on Aging) was formed in an attempt to create standards for adult day care services.

Only 26 states (including the District of Columbia) currently license or certify adult day care centers; 15 other states set standards for centers that receive state funding. Only 12 states have no regulation whatsoever.

National Council on Aging (NCOA): One of the largest national organization with a specialized interest in aging issues and services.

VIII. Acronyms and Abbreviations

AAA	Area Agency on Aging
AAA	Area Agencies on Aging
AARP	American Association for Retired Persons
ACTION	Federal Agency administering volunteer programs
ADLs	Activities of Daily Living
AoA	Administration on Aging
ASA	American Society on Aging
CHHA	Certified Home Health Agency
CORF	Comprehensive Outpatient Rehabilitation Facility
DFTA	New York City Department for the Aging
DME	Durable medical equipment (e.g., beds, ventilators)
DMH, MR & AS	New York City Department of Mental Health, Mental Retardation and Alcoholism Services
DRG	Diagnostic Related Groups
DSS	New York State Department of Social Services
EISEP	Expanded In-Home Services for Elderly Persons
EPIC	Elderly Pharmaceutical Insurance Coverage
GSA	Gerontological Society of America
HCFA	Health Care Financing Administration
HEAP	Home Energy Assistance Program
HHS	United States Department of Health and Human Services
HRA	Human Resources Administration
HUD	Housing and Urban Development
LTC	Long Term Care
LTHHC	Long Term Home Health Care Program
NCOA	National Council on the Aging
NCVA	National Center for Vision and Aging
NIA	National Institute on Aging
OAA	Older Americans Act
OASDI	Old Age, Survivors, and Disability Insurance
OMH	New York State Office for Mental Health
PA	Public Assistance
P&A	Protection and Advocacy
PRI	Patient Review Instrument
PSA	Protective Services for Adults

RSVP	Retired Senior Volunteer Program
RUGS	Resource Utilization Groups
SCP	Senior Companion Program
SCRIE	Senior Citizens Rent Increase Exception
SNF	Skilled Nursing Facility
SSI	Social Security Income

Part 2. ALPHABETICAL INDEX OF TERMS

<u>Term</u>	<u>Defined on Page</u>
AARP	32
Abuse	20
Acute	18
Action	6
Activities of Daily Living	2
Adaptive Behavior	2
Adaptive Equipment	18
Administration on Aging	5
Adult Day Care	7
Affective Disorders	18
Age	1
Ageism	1
Aging	1
Aging-In	1
American Association of Homes for the Aged	32
American Geriatrics Society	32
Aphasia	18
Apraxia	18
Ataxia	18
Area Agencies on Aging	6
Caregiver	3
Caregiver Burden	3
Care Management	7
Certified Home Health Care	8
Committee	27
Congregate Housing Programs	8
Congregate, Homebound Meals	8
Conservatee	25
Conservator	26
Continuing Care Residence	8
CORF	8
Counseling, Crisis Intervention	9
Department of Social Services- Protective Services for Adults	6
Decubitus Ulcer	18
Dementia	18
DMS-I	17
Edema	19
Elder or Elderly	1

<u>Term</u>	<u>Defined on Page</u>
Elder Care	3
Elder Law	9
Emergency Response System	9
Financial Exploitation	20
Food Stamps	9
Foster Grandparents	9
Frail Elderly	1
Functional Age	1
Functional Disability	3
Geriatrics	2
Gerontology	2
Groups/Categories of Age	1
Guardian ad litem	28
Health Care Proxy, Living Will	29
Home Energy Assistance Program	10
Home Health Care	10
Homemaking, Housekeeping, Chores	10
Hospice	10
Incompetence	23
Information and Referral	10
Instrumental Activities of Daily Living	3
IV Therapies	19
Legal Process	21
Long Term Home Health Care	11
MII-Q	16
MDS+	16
Medicaid	11
Medicare	11
Mental Capacity/Incapacity	23
Natioanl Council on Aging	33
National HomeCaring Council	32
National Hospice Organization	32
National Institute on Adult Day Care	32
Neglect	20
N.Y. State Elderly Pharmaceutical Insurance Coverage	12
NORC	12

<u>Term</u>	<u>Defined on Page</u>
Older Americans Act	5
On-Lok Senior Services	12
Parkinson's Disease	19
Physical Abuse	20
Power of Attorney, Durable	28
Power of Attorney	
Prosthesis	19
PRI	16
Primary Degenerative Dementia	18
Psychogeriatrics	2
Psychological Abuse	20
Public Assistance	12
Public Housing	13
RAI	17
Representative Payee	24
Reverse Mortgage	13
Respite	13
ROM	19
Sandwich Generation	4
Senescence	19
Senior Centers	13
Senior Citizen Rent Increase	14
Exemption	
Senior Community Employment	14
Program	
Senior Companion Program	14
Service Corp of Retired	
Executives	15
Skilled Nursing Facility	14
Social Health Maintenance	15
Organization	

<u>Term</u>	<u>Defined on Page</u>
Social Security Act of 1935	5
State Office for the Aging	6
Stroke	19
Telephone Reassurance	16

APPENDIX # 2

Unmet Mental Health Needs of Senior Adults

Below please find a list of the unmet mental health and related psychosocial and support needs for the elderly identified via the key informant interview process. Based upon your experience (in Agency and related practice, personal experience, etc) please take a few moments to categorize these needs into one of three categories (i.e. high, medium or low need).

Identifying that a service is needed does not automatically mean that _____ is the best or appropriate agency to meet this need. For purposes of this needs ranking, please use the following definitions:

High Need - It is very difficult to obtain this service for senior adults; addition of this service or support has the potential to make a significant difference in the lives of older adults.

Medium Need - This is an important service; it is available in limited degree

Low Need - This service is provided by other agencies; its potential impact is minimal.

DK - I don't know the scope of need for this service.

<u>Needs</u>	<u>Ranking</u> <u>(High, Medium, Low, D.K)</u>	<u>Ranking</u> <u>(1-5)</u>
Outpatient "clinic" services with a geropsychiatric expertise	_____	_____
On-site services at e.g. senior centers and senior housing	_____	_____
Consultation and education services at senior center, adult day health services, etc.	_____	_____
Mental health services to the home bound	_____	_____
Crisis mobile mental health team	_____	_____

<u>Needs</u>	<u>Ranking</u> <u>(High, Medium, Low, D, K)</u>	<u>Ranking</u> <u>(1-5)</u>
Outreach	_____	_____
Psychiatric backup to existing social service programs	_____	_____
<u>Day treatment programs</u> <u>for</u>		
A. late onset or chronic mental illness	_____	_____
B. Dementia	_____	_____
C. HIV Positive/AIDS	_____	_____
<u>Dementia related services</u>		
A. Treatment of behavioral symptomatology by a psychiatrist	_____	_____
B. Group home/residence for individuals at the early stage of the disease	_____	_____
C. Mental health services for individuals at the early stage of the disease	_____	_____
D. Caregiver supports	_____	_____
Case management	_____	_____
Substance Abuse services	_____	_____
<u>Group Services-"Therapeutic"</u>		
A. For elders who have been abused	_____	_____
B. HIV Positive/AIDS	_____	_____
C. For parents of:		
- The chronically mentally ill	_____	_____
- Alcoholics	_____	_____
D. Bereavement	_____	_____
E. Depressed older adults	_____	_____
<u>Group Services/FLE/Selfhelp/ Education</u>		
A. Bereavement groups	_____	_____
B. Newly or planning to retire	_____	_____
C. HIV Positive/AIDS education	_____	_____
D. For Soviet emigres	_____	_____

<u>Needs</u>	<u>Ranking</u> <u>(High, Medium, Low, D.K)</u>	<u>Ranking</u> <u>(1-5)</u>
E. The realities of entitlements	_____	_____
F. Women alone	_____	_____
G. Caregivers (non dementia)	_____	_____
H. Grandparents in the parental role	_____	_____
I. Mid-life women (preventive)	_____	_____
J. Representative Payee	_____	_____
K. Health Care Proxys	_____	_____
L. Informal gatekeepers	_____	_____
Volunteer opportunities	_____	_____
Representative Payee/ Conservatorship (Acting as)	_____	_____
<u>For the home bound and isolated</u>	_____	_____
A. Friendly visitors	_____	_____
B. Telephone support groups/ socialization	_____	_____
Services for the Homeless Mentally Ill	_____	_____
Residential services for the chronically mentally ill	_____	_____
Services for individuals with dual diagnoses	_____	_____
Respite	_____	_____
Training for non-mental health clinicians in the identification of mental illness	_____	_____
Training for mental health clinicians in the specifics of geriatric mental health	_____	_____

<u>Needs</u>	<u>Ranking</u> <u>(High, Medium, Low, D.K)</u>	<u>Ranking</u> <u>(1-5)</u>
Research into effective treatment strategies	_____	_____
Public education to address issues of stigma	_____	_____
Provision of services that are bilingual and/or culturally sensitive	_____	_____
Improved linkages and collaboration between agencies	_____	_____
Transportation	_____	_____

Please return to the above list and identify the 5 programs/services that you think are the highest priority for JBFCIS involvement. 1= highest priority. Please use the column marked "ranking 1-5."

Thank you for your assistance.

Name (optional)

AW:jd
AW124

APPENDIX #3

Log Format Used to Track Planning Process

[illegible]

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