DOCUMENT RESUME

ED 306 316 UD 026 502

TITLE	Mental Health and the Elderly: Issues in Service Delivery to the Hispanic and Black Community. Part I. Hearing before the Select Committee on Aging. House of Representatives, One Hundredth Congress, Second Session (Long Island City, New York).
INSTITUTION	Congress of the U.S., Washington, D.C. House Select Committee on Aging.
REPORT NO	House-Comm-Pub-100-674
PUB DATE	13 May 88
NOTE	151p.; For part II, see RC 016 908.
AVAILABLE FROM	Superintendent of Documents, Congressional Sales Office, U.S. Government Printing Office, Washington, DC 20402.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01/PC07 Plus Postage.
DESCRIPTORS	Agency Cooperation; *Blacks; Cooperative Planning; Delivery Systems; Depression (Psychology); Ethnic Groups; *Health Needs; Hearings; Hispanic Americans; Intercultural Programs; Mental Disorders; *Mental Health Programs; Minority Groups; *Older Adults; Outreach Programs; *Puerto Ricans; Racial Bias; Racial Differences; *Urban Programs
IDENTIFIERS	*New York (New York)

ABSTRACT

This hearing examines the mental health needs of America's Black and Hispanic elderly in New York State and, particularly, in the New York City area, and considers solutions for service delivery. Seven expert witnesses testified. Few research studies specifically target aged Blacks and Puerto Ricans; however, many minority elderly share the following characteristics of persons who are at-risk of mental illness: (1) low income; (2) unmarried; (3) low education; and (4) poor physical health. Elderly Puerto Ricans have an extremely high level of depressive symptoms, and Puerto Rican women have significantly higher levels than men. Poor English language skills and very low acculturation contribute to the vulnerability of elderly Puerto Ricans. Aged Blacks suffer from the physical and psychological effects of a lifetime of racial oppression. All witnesses agreed on the need for a comprehensive, interagency approach to mental health service delivery that utilizes the clients' social networks. Service delivery to older Puerto Ricans should include bilingual services. Delivery to older Blacks should include holistic assessment and treatment planning. Other factors to be considered include the following: (1) affordability; (2) improvement of existing day treatment and inpatient services; (3) development of mobile treatment services; and (4) service for elderly mentally disabled homeless. Each report is accompanied by a list of references. (FMW)

MENTAL HEALTH AND THE ELDERLY: ISSUES IN SERVICE DELIVERY TO THE HISPANIC AND BLACK COMMUNITY

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

MAY 13, 1988, LONG ISLAND CITY, NY

Comm. Pub. No. 100-674

PART I

Printed for the use of the Select Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

88-209 ⇌ WASHINGTON : 1988

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MENTAL HEALTH AND THE ELDERLY: ISSUES IN SERVICE DELIVERY TO THE HISPANIC AND BLACK COMMUNITY

Friday, May 13, 1988

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Long Island City, NY.

The committee met, pursuant to notice, at 9:50 a.m., at the Queensbridge Houses Community Center, Hon. Edward R. Roybal (Chairman of the Select Committee on Aging), presiding.

Members present: Representatives Roybal, Manton, and Garcia.

Staff present: Manuel R. Miranda, Staff Director; Edgar E. Rivas, Professional Staff; Diana Jones, Staff Assistant; and Melissa Schulman, Legislative Assistant.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

The CHAIRMAN. Ladies and gentlemen, the committee will now come to order.

I am Congressman Ed Roybal from the State of California. I am chairman of the House Select Committee on Aging.

I'd like to thank each and every one of you for being present this morning to hear testimony from a group of expert witnesses.

The purpose of today's hearing is to examine the mental health needs of America's Black and Hispanic elderly and to consider solutions for meeting their unmet needs.

Two additional field hearing will be held, one in Denver and the other in Los Angeles, where we will target mental health issues on elderly Blacks, Hispanics, Asian/Pacific Islanders, and American Indians.

These four groups were selected because the mental health needs of their respective ethnic communities are frequently unknown, leading to inappropriate policy decisions and service system development. The major similarity among these culturally diverse elderly is their limited access to money, to power, and to institutional support. These groups also share the historical, cultural, and psychological effects of overt racial and ethnic discrimination.

Today's hearing hopes to bring to the public and the Congress' attention the need for a truly comprehensive system of mental health services, one that will complement and enhance the quality of life for all Americans. The elderly as a whole, and Black and Hispanic specifically, represent an underserved portion of our population when it comes to mental health services and delivery.

Often these elders lack sufficient income to pay the deductibles and premiums required for Medicare.

Furthermore, they are often victims of poor services from professionals harboring racist or ageist attitudes. Asian Americans and Hispanic Americans often do not receive services because of language barriers. Minority elderly in the urban setting are often forced to seek mental health care some distance from their home and community because few mental health professionals work in the central city.

As a whole, elderly persons make up almost 12 percent of the American population but represent only about 6 percent of the persons served by community mental health centers and only about 2 percent of those served by private therapists.

For too long, mental health concerns and care have been a neglected priority in American health care. This neglect will be documented in my committee report which will be entitled "Mental Health and Minority Aging".

This report will be released to the public after the field hearings have been completed. We'll try to make some comparison as to what the basic problems are in New York relative to Denver and Los Angeles. It is my belief that we will find very little differences among the three cities as to the basic service needs that we will be addressing this morning.

What I'm saying is that no matter where you go, there is a problem. The biggest problem of all is the way we in the Federal Government are addressing ourselves to that specific problem. What we learn here today will be of great help to us. We sincerely hope that once that report is written, it will be disseminated widely to both experts and nonexperts with the hope that the report will encourage these individuals to communicate their concerns to their respective representatives.

At this point, I would like to introduce Congressman Manton, a member of the Committee on Aging, who has been very active in matters of health and education, but particularly active when it comes to those problems that effect the senior citizen community of the United States. The work that he's done in Congress is the kind of work that is done only by individuals who really care.

There are those in the Congress of the United States that at times do things just automatically. There are others that do it not only automatically because that is their instinct, but do it from the heart because they care and they follow through.

Congressman Thomas Manton is that kind of an individual. It's with a great deal of pleasure that I now yield to Congressman Manton to make whatever remarks he wishes to make. At the conclusion of his remarks, we will recognize the experts that sit before us and the formal part of the hearing will then commence.

Congressman Manton.

STATEMENT OF REPRESENTATIVE THOMAS J. MANTON

Mr. MANTON. Thank you very much, Mr. Chairman. Good morning, everybody. How many of you were in Washington the other day at the housing rally? A good show of hands. We're about to visit with you today on a slightly different subject from housing.

I'm especially pleased to welcome the Chairman of the Select Committee on Aging, Congressman Ed Roybal from the great State of California to our Congressional District here in New York.

Ed Roybal was here a few years ago for a hearing on Social Security, and it's a pleasure to have him back. Chairman Roybal is one of the key leaders in the Congress working to protect our Nation's senior citizens. As Chairman of the Select Committee on Aging, he has worked to protect Social Security benefits, to improve the Medicare system and to end employment discrimination against all Americans.

Basically, whenever there is an issue of concern to the elderly, Congressman Ed Roybal is there fighting on their behalf.

I expect that we will be joined this morning by our colleague from the Bronx, Congressman Bob Garcia. Although I know he had a busy schedule, I expect he'll be here before we close. Although Congressman Garcia is not a member of the Select Committee on Aging, his commitment to the elderly is well known in Congress. For many years he's been a staunch advocate for senior citizen housing while serving on the House banking committee on the housing subcommittee as I do.

Much discussion of late has centered on the importance of improving health care and expanding the Medicare system to protect older Americans during a catastrophic illness. However, little attention has been paid to the mental health needs of older Americans and the current level of available services.

This morning's hearing will begin the Select Committee on Aging's study of this equally important issue. We will be specifically focusing on the needs and experiences of older Black and Hispanic Americans. Current research suggests, and the available statistics are rather incomplete, that up to one quarter of American's elderly are in need of professional, mental health services.

Elderly individuals often have special health needs, and minority elderly must often deal with the so-called double jeopardy of being both elderly and at the same time a member of a minority group.

Older Americans experience a high incidence of depression often associated with the loss of a spouse or alcohol abuse. The misuse of prescription drugs is common among the elderly as well.

Unfortunately, our current health policy seems to leave a large number of elderly without access to essential health services that they need. Nursing home residents rarely have access to the mental health services that they need.

I want to commend Congressman Roybal for calling attention to this serious problem. It is essential the Congress begin to examine ways to improve access to mental health services and to increase the number of mental health care professionals that are trained to specifically deal with the mental health needs of the elderly.

I'd like to thank the audience and the witnesses for joining us. Today's hearing will provide important information from the community about ways to improve America's mental health care system.

Congressman Roybal, myself and other members of the committee will be taking the record of today's hearing back to our colleagues in the Congress. You can be assured we'll be working to develop a strong, Federal mental health initiative.

Thank you all. Mr. Chairman?

The CHAIRMAN. The first witness this morning is Rita Mahard, research scientist with the Hispanic Research and Development Center at Fordham University.

Ms. Mahard, you may proceed in any manner that you wish.

STATEMENT OF RITA MAHARD, PH.D., RESEARCH SCIENTIST, HISPANIC RESEARCH CENTER, FORDHAM UNIVERSITY, BRONX, NY

Dr. MAHARD. Thank you, Mr. Chairman.

Mr. Chairman and members of the Select Committee, I am Dr. Rita Mahard. I am a research scientist at Fordham University's Hispanic Research Center, one of several minority group research centers funded by the National Institute of Mental Health.

Accompanying me this morning is Dr. Lloyd Rogler, the director of the Hispanic Research Center.

I appreciate this opportunity to testify before the Select Committee on Aging. In my statement, Mr. Chairman, I will present some current research findings on the mental health status of the elderly Puerto Rican population. These findings are based on a recently completed survey that I conducted of a representative sample of 1,000 Puerto Ricans aged 55 and over residing in households in the New York metropolitan area.

I will first present some results relevant to depression in this population, and I will then talk about factors that are associated with psychological disorder more generally. At both points, I will indicate how elderly Puerto Ricans compare with the general elderly population.

Since depressive illness is the most prevalent of the major mental disorders, our study included a widely used survey measure of depressive mood. The depression measure assesses the extent to which 20 symptoms associated with clinical depression have been experienced by the person in the last week.

National data show that persons between the ages of 55 and 74 have an average score of 8.6 on this measure out of a possible 60 points. This represents a low to moderate level of depressive symptoms, and can be thought of as roughly equivalent to experiencing 4 of the 20 symptoms occasionally throughout the week.

Puerto Ricans between the ages of 55 and 74 have an average score of 15.6 on this measure. This represents an extremely high level of depressive symptoms, and can be thought of as roughly equivalent to experiencing 5 of the 20 symptoms for the entire week, or most of the week.

Elderly Puerto Rican women have significantly higher levels of depressive symptoms than men. In terms of age, the highest depression scores are found for persons aged 75 and over. Symptom levels are the same for persons between 55 and 74 years of age.

The average score on this measure for elderly Puerto Ricans is higher than has been reported in the literature for any other elderly group. This difference in symptom levels between elderly Puerto Ricans and the general population of elderly is thus very striking. How are we to understand it?

One way to understand this difference is to examine our data in light of what community epidemiologic studies tell us about the

various risk factors for mental illness and distress. These community studies tell us that psychological disorder occurs more frequently among people who are not married, low in socioeconomic status and in poor physical health.

In addition, some studies of migrants and immigrants have indicated that low acculturation is also a risk factor—psychological disorder occurs more frequently among people who are on the periphery of the dominant American culture.

The data from the survey of elderly Puerto Ricans indicate that Puerto Ricans are heavily represented on all of these risk factors for psychological disorder and distress. Thus, it is not surprising to find that elderly Puerto Ricans have very high levels of depressive symptoms.

In terms of marital status, while 40 percent of elderly Puerto Ricans are currently married, over half are separated, divorced or widowed. Women are significantly less likely than men to be currently married. Persons aged 65 and over are also less likely to be married due to increased widowhood.

The socioeconomic disadvantage of elderly Puerto Ricans can be seen on each of three major indicators—education, occupation and income. In terms of education, elderly Puerto Ricans have little formal schooling. Twenty percent have less than a third grade education, and 43 percent have less than a fifth grade education. Only 12 percent have completed high school.

In terms of employment, older Puerto Ricans have been concentrated in low level service and laborer occupations. Fifty-one percent report major lifetime occupations as laborers or machine operators, particularly textile sewing machine operators. Twenty-one percent have held service jobs for the majority of their lives. Only 11 percent have held professional or technical positions for the majority of their work lives.

Our data suggest that the difficult working conditions and the level of physical demand associated with service and laborer occupations have taken a toll on the health of this population and resulted in an earlier age for leaving work than would otherwise have been expected.

Although 57 percent of elderly Puerto Ricans are between 55 and 65 years of age, only 17 percent of elderly Puerto Ricans are currently working for pay. Fifty-three percent of those who were once employed cited health as their major reason for leaving work.

The employment experience of older Puerto Ricans has also resulted in low incomes, inadequate pension coverage and high participation in public assistance programs. Census data indicate that 24 percent of all elderly persons were living below the poverty level in 1985, but 39 percent of elderly Puerto Ricans were. Thirty-eight percent of the respondents in our study received Supplemental Security Income in 1985, and 42 percent received food stamps. Only 7 percent received income from pensions or annuities.

Our data show that incomes are lower and participation in public assistance programs is higher among women and among older persons.

The survey also collected information on various aspects of physical health. Here I will mention only one, and that is the older person's ability to carry out some basic activities of daily living that

have been found to be important determinants of the person's ability to remain independently in the community. We asked about 6 such activities, for example; dressing oneself, climbing stairs, and moving around the house.

Fully 34 percent of Puerto Ricans aged 55 and over need help to manage at least one of these basic, simple activities and most of this 34 percent require help with more than one activity. At age 65 and over, 49 percent of Puerto Ricans need help with one or more of these activities. This 49 percent contrasts with only 22 percent who were identified as needing such help in a national survey of the elderly.

Women have somewhat higher levels of functional impairment than men, but the difference is not a strong one. Age is more strongly associated than gender with levels of impairment, and impairment is significantly higher for persons aged 75 and over.

As a first generation population, elderly Puerto Ricans have also confronted serious acculturative difficulties, particularly in the area of language. Sixty-one percent of our respondents indicated that they speak either no English at all or only a little English.

Difficulties with English are experienced in a variety of settings, the most common being in the encounter with health and social service agencies. Forty-four percent of older Puerto Ricans say that English poses problems for them when they need to deal with government agencies, hospitals, clinics and other bureaucracies.

Less common, but still affecting a significant number of these older people, are language problems that are so severe that they impede the person's ability to carry out routine transactions such as shopping or using public transportation. Twenty-two percent of older Puerto Ricans have language problems of this type.

Difficulties with English are somewhat more common among women, and considerably more common among older than younger persons. The most severe English problems, those that interfere with daily functioning, are particularly common among those aged 75 and over.

Our data on a number of known risk factors for mental illness are thus quite clear. Disrupted marital status, socioeconomic disadvantage, poor physical health and low acculturation place elderly Puerto Ricans as a population at significant risk for psychological disorder and distress. Thus, the much higher depression scores of elderly Puerto Ricans relative to the general population of elderly noted earlier come as no surprise.

Our data also indicate that within the elderly Puerto Rican population, persons who are worse off in terms of the risk factors are the very people with the highest depression scores. Thus, the unmarried, the very poor, the functionally impaired and those with severe English problems constitute particularly high risk subgroups within the Puerto Rican population.

In summary, Mr. Chairman, our findings on the mental health status of elderly Puerto Ricans are a cause for concern. These older people have strikingly higher levels of depressive symptoms than the general population of elderly. Older Puerto Ricans are also disproportionately represented among groups known to be at risk for psychological disorder more generally relative to other older people; they are more likely to be unmarried, to be of low socioeco-

nomic status and to be in poor physical health. Elderly Puerto Ricans are also a low acculturation group, and this places them at additional risk.

Mr. Chairman, I thank you for the opportunity to testify at this hearing. I am pleased to answer any questions that you and the members of the committee might have.

[The prepared statement of Dr. Mahard follows:]

Testimony of

Rita Mahard, Ph.D.

Research Scientist
Hispanic Research Center
Fordham University
Bronx, New York

before the

Select Committee on Aging

House of Representatives

May 13, 1988

Mr. Chairman and Members of the Select Committee:

I am Dr. Rita Mahard. I am a Research Scientist at Fordham University's Hispanic Research Center, one of several minority group research-centers funded by the National Institute of Mental Health.[1]

I appreciate this opportunity to testify before the Select Committee on Aging. In my statement, Mr. Chairman, I will present some current research findings on the mental health status of the elderly Puerto Rican population. These findings are based on a recently completed survey that I conducted of a representative sample of 1,000 Puerto Ricans aged 55 and over residing in households in the New York metropolitan area.[2]

I will first present some results relevant to depression in this population, and I will then talk about factors that are associated with psychological disorder more generally. At both points, I will indicate how elderly Puerto Ricans compare with the general elderly population.

Since depressive illness is the most prevalent of the major mental disorders (Tueting et al., 1983), our study included a widely used survey measure of depressive mood. The depression measure assesses the extent to which 20 symptoms associated with clinical depression have been experienced by the person in the last week (Radloff, 1977; see also, Mahard, 1988).

National data show that persons between the ages of 55 and 74 have an average score of 8.6 on this measure out of a possible 60 points (Sayetta & Johnson, 1980:8). This represents a low-to-moderate level of depressive symptoms,

and can be thought of as roughly equivalent to experiencing 4 of the 20 symptoms occasionally during the week.

Puerto Ricans between the ages of 55 and 74 have an average score of 15.6 on this measure. This represents an extremely high level of depressive symptoms, and can be thought of as roughly equivalent to experiencing 5 of the 20 symptoms for the entire week or most of the week.

Elderly Puerto Rican women have significantly higher levels of depressive symptoms than men. In terms of age, the highest depression scores are found for persons aged 75 and over; symptom levels are the same for persons between 55 and 74 years of age.

The average score on this measure for elderly Puerto Ricans is higher than has been reported in the literature for any other elderly group (cf. Himmelfarb & Murrell, 1983; Murrell et al., 1983; Sayetta & Johnson, 1980; White et al., 1986:141). This difference in symptom levels between elderly Puerto Ricans and the general population of elderly is thus quite striking. How are we to understand it?

One way to understand this difference is to examine our data in light of what community epidemiologic studies tell us about the various risk factors for psychological disorder and distress. These community studies tell us that psychological disorder and distress occur more frequently among people who are not married, low in socioeconomic status and in poor physical health (Radloff, 1980; Sayetta & Johnson, 1980; Turner & Noh, 1988).

In addition, some studies of migrants and immigrants have indicated that low acculturation is also a risk factor-- psychological disorder occurs more frequently among people who are on the periphery of the dominant American culture (cf. Lang et al., 1982; Szapocznik et al., 1980).

The data from the survey of elderly Puerto Ricans indicate that Puerto Ricans are heavily represented on all of these risk factors for psychological disorder and distress. Thus, it is not surprising to find that elderly Puerto Ricans have very high levels of depressive symptoms.

In terms of marital status, while 40 percent of elderly Puerto Ricans are currently married, over half (54 %) are separated, divorced or widowed. Women are significantly less likely than men to be currently married (26 versus 60 %). Persons aged 55 and over are also less likely to be married due to increased widowhood.

The socioeconomic disadvantage of elderly Puerto Ricans can be seen on each of three major indicators: education, occupation and income. In terms of education, elderly Puerto Ricans have little formal schooling. Twenty percent have less than a third grade education, and 43 percent have less than a fifth grade education. Only 12 percent have completed high school.

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technical positions for the majority of their work lives.

Our data suggest that the difficult working conditions and the level of physical demand associated with service and laborer occupations have taken a toll on the health of this population and resulted in an earlier age for leaving work than would otherwise have been expected. Although 57 percent of elderly Puerto Ricans are between 55 and 65 years of age, only 17 percent of elderly Puerto Ricans are currently working for pay. Fifty-three percent of those who were once employed cited health as their major reason for leaving work.

The employment experience of older Puerto Ricans has also resulted in low incomes, inadequate pension coverage, and high participation in public assistance programs. Census data indicate that 24 percent of all elderly persons were living below the poverty level in 1985, but 39 percent of elderly Puerto Ricans were (U.S. Bureau of the Census, 1987). Thirty-eight percent of our respondents received Supplemental Security Income in 1985, and 42 percent received food stamps. Only 7 percent received income from pensions or annuities.

Our data show that incomes are lower and participation in public assistance programs is higher among women and among older persons.

The survey also collected information on various aspects of physical health. Here I will mention only one, and that is the older person's ability to carry out some basic activities of daily living (ADL) that have been found

to be important determinants of the ability to remain independently in the community (cf. Wingard et al., 1987). We asked about 6 such activities, for example, dressing oneself, climbing stairs, and moving around the house.

Fully 34 percent of Puerto Ricans aged 55 and over need help to manage at least one of these basic, simple activities, and most of these require help with more than one activity. At age 65 and over, 49 percent of Puerto Ricans need help with 1 or more of these activities. This 49 percent contrasts with only 22 percent who were identified as needing such help in a national survey of the elderly (unpublished analysis of data from Shanas, 1982).

Women have somewhat higher levels of functional impairment than men, but the difference is not a strong one. Age is more strongly associated than gender with levels of impairment, and impairment is significantly higher for persons aged 75 and over.

As a first-generation population, elderly Puerto Ricans have also confronted serious acculturative difficulties, particularly in the area of language. Sixty-one percent of our respondents indicated that they speak either no English at all or only a little English.

Difficulties with English are experienced in a variety of settings, the most common being in the encounter with health and social service agencies. Forty-four percent of older Puerto Ricans say that English poses problems for them when they need to deal with government agencies, hospitals, clinics, and other bureaucracies.

Less common, but still affecting a significant number of these older people, are language problems that are so severe that they impede the person's ability to carry out routine transactions such as shopping or using public transportation. Twenty-two percent of older Puerto Ricans have language problems of this type.

Difficulties with English are somewhat more common among women than men, and considerably more common among older than younger persons. The most severe English problems, those that interfere with daily functioning, are particularly common among those aged 75 and over.

Our data on a number of known risk factors for mental illness are thus quite clear. Disrupted marital status, socioeconomic disadvantage, poor physical health and low acculturation place elderly Puerto Ricans as a population at significant risk for psychological disorder and distress. Thus, the much higher depression scores of elderly Puerto Ricans relative to the general population of elderly noted earlier come as no surprise.

Our data also indicate that within the elderly Puerto Rican population, persons who are worst off in terms of the risk factors are the very people with the highest depression scores. Thus, the unmarried, the very poor, the functionally impaired and those with severe English problems constitute particularly high risk subgroups of Puerto Rican elders.

In summary, Mr. Chairman, our findings on the mental health status of elderly Puerto Ricans are a cause for concern. These older people have

strikingly higher levels of depressive symptoms than the general population of elderly. Older Puerto Ricans are also disproportionately represented among groups known to be at risk for psychological disorder more generally--relative to other older people, they are more likely to be unmarried, to be of low socioeconomic status and to be in poor physical health. Elderly Puerto Ricans are also a low acculturation group, and this places them at additional risk.

Mr. Chairman, I thank you for the opportunity to testify at this hearing. I am pleased to answer any questions that you and the members of the Committee might have.

NOTES

1 -
The Hispanic Research Center is funded by National Institute of Mental Health Grant number MH30569 from the Minority Research Resources Branch to Dr. Lloyd Rogler.

2
This research is supported by National Institute of Mental Health Grant number MH40881 from the Mental Disorders of the Aging Research Branch to Dr. Mahard.

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The CHAIRMAN. Thank you very much.

The chair will now recognize Dr. Barbara Jones-Morrison. Will you proceed in any manner that you may desire?

STATEMENT OF DR. BARBARA JONES-MORRISON, D.S.W., ASSISTANT DIRECTOR, PROGRAM DEVELOPMENT, NEW YORK STATE OFFICE OF MENTAL HEALTH

Dr. JONES-MORRISON. Thank you, Mr. Chairman.

My name is Barbara Jones-Morrison, and I'm on the staff of the New York State office of Mental Health.

I am very pleased to have been asked to address the mental health needs of the Black elderly. For several years I have been involved in gerontological research with special attention to the needs of members of racial and ethnic minority groups. My research perspectives have been enhanced by several years of employment in New York State government in the policy ad planning area related to the design and delivery of long-term care services.

I would like to begin with a brief demographic profile of the Black older person in the United States, with special attention to those factors which are likely to increase the prevalence of mental and emotional distress. It is important to remember that there are significant variations on these patterns among the Black elderly. Nevertheless, dominant patterns are useful for assessing population based patterns of risk and need.

The gerontological literature indicates that mental illness among the elderly can be attributed to several factors which characterize the normal aging process. These are increased vulnerability to physical illness, loss of income and self esteem associated with retirement from the labor force, death of family members and friends, and increased isolation resulting from the shrinking of social networks and opportunities for social interaction.

The Black elderly are especially vulnerable to many of these risk factors. In 1971 the Committee on Aging of the Group for the Advancement of Psychiatry stated being Black and aged frequently means the piling up of life problems associated with each characteristic.

Older Blacks will constitute an ever growing percentage of the Black population and the older population in the United States. They will bring with them into old age many problems which increase their vulnerability to mental illness.

We know that very advanced aged is associated with higher incidence of dementia. Life expectancy tables reveal a cross over phenomenon in which Blacks over the age of 75 tend to outlive their white counterparts. If this pattern continues in the future, Blacks will be an increasing percentage of the old-old, who are the highest users of long-term care for mental and physical disabilities. The most rapidly growing segment of the Black elderly population are women 80 years of age and older.

We know that family and social support can either increase or diminish the risk of illness. The availability of a spouse and children appears to reduce the isolation of old age. Older Black women are much more likely to enter old age as widows or divorces.

On the other hand, Black women are more likely to have had children compared to white women and the unavailability of spousal support may be offset, to some extent, by the presence of adult children who can provide both instrumental and emotional support. The larger numbers of Black older women living alone, particularly in New York City, may have implications for increased vulnerability to isolation and depression.

With regard to environmental stressors, there are more Black aged—53 percent—who live in central cities compared to whites, only 27 percent. The environmental challenges of complex urban living place greater demands on the Black elderly. They are more likely to be victimized by the gentrification of inner cities.

As old neighborhoods are destroyed through neglect or urban development, old support networks are dismantled. The fear of crime among older urban dwellers is well documented.

Service systems in large urban areas are fragmented and difficult to access and negotiate. Many Black elderly allow medical and mental health needs to reach crisis proportions before the severity of the problem forces them to face the challenge of seeking help.

With regard to the effects of poverty, the income levels of older Blacks are the clearest indicators of the effects of historical employment and educational discrimination. The older Black woman clearly is the poorest of the poor. Forty-one percent of older Black women are poor, as compared to 28 percent of Black males, 15 percent of white females and 8 percent white males.

The elderly poor are at increased risk of chronic illness and disability, poor nutrition, inadequate housing and lack of financial resources to purchase needed items and service. Each of these leads to higher rates of mental and emotional distress.

The presence of debilitating physical conditions has been shown to be correlated with higher levels of mental disorder. The chronically ill are more likely to be depressed and resort to the abuse of alcohol or other drugs to self mediate. Older Blacks show higher rates of death and chronic disability due to cancer, diabetes, heart disease, stroke and cirrhosis of the liver as compared to whites of the same age. This is particularly true of the older Black male.

I would refer the audience here to the report of the Task Force on Black and Minority Health that was produced in 1985.

Psychological distress has physical consequences and vice versa. Because the elderly in general, and elderly from racial and ethnic minority groups in particular, are reluctant to define a problem as a mental problem, they are more likely to somatize emotional stress and seek help from medical personnel. Seeking medical attention does not carry the same stigma and shame associated with seeking psychiatric services.

With regard to alcohol abuse, heavy use of alcohol is also a mask for depression in the elderly. Information is sparse on specific drinking patterns among the Black elderly. There is some research that shows that Black males report higher rates of heavy drinking after the age of 30.

Mortality rates from cirrhosis of the liver have declined consistently among all race/sex groups since 1973, but they remain disproportionately high for Black Americans. This would indicate that

alcohol abuse remains a significant health and mental health problem among Blacks including the elderly.

The focus on Black psychological well being emerged largely from the psychology of oppression literature of the 1950's when it was suggested that all Blacks carried the mark of oppression and were therefore psychologically unhealthy.

In the emerging literature, Blacks were portrayed, the elderly in particular, as displaying great psychic and physical resilience in the face of overwhelming oppression, but there was really no serious inquiry into the personal well being and psychological adjustment of the Black elderly.

Recently, this state of affairs has changed as scholars have begun to consider Black mental health and adjustment, particularly how group status and group membership impact the subjective sense of well being.

As James Jackson and his colleagues at the University of Michigan's survey research center point out: more recent work focuses on mental health and illness issues of the elderly in a multi-faceted perspective. There is a great concern for mental health, both as the absence of specific disease states, and as the presence of a positive sense of well being and a generally positive view of life.

This multi-dimensional and multi-faceted view of mental illness and mental health is certainly appropriate in an examination of the mental status of Black Americans. As an oppressed minority, many of their mental health problems are as much, if not more, a function of environment than the outcome of intra-psychic conflict. The emphasis on environmentally produced stress as a biopsychosocial predictor of mental illness is a decisive breakthrough in the Black mental health literature.

As a subset of the Black population, the Black elderly are subject to environmental stressors to which they have adapted over a lifetime. When they do seek help for problems they encounter in adjusting, they are likely to experience forces common to most Blacks with similar needs.

In view of the emphasis on environmentally induced stress, I would like to briefly consider some of the major themes related to Black elderly well being and external sources of psychological distress in this population.

I'd like to note that there are extensive citations throughout my written testimony to specific studies which I will not mention in my verbal presentation.

The infantilization of Blacks that occurred during slavery lead to the stereotypic notion that Blacks, even the elderly, were child like and happy, and incapable of experiencing the depression and affective disorders experienced by whites. Although this type of thinking has diminished over time, stereotypes and myths die hard and vestiges of this attitude remain among the general population, including health care providers.

The research on minority aging has in part focused on tempering these stereotypes by examining self perceived and self reported perceptions of aging and life satisfaction among older Blacks.

We know that functional status as a reflection of underlying health and stability, determines when a person feels physically and psychologically old, regardless of actual chronological age. Thus, ef-

forts to assess the perceived or actual mental health of an older person, must include attention to functional status.

The research on life satisfaction has produced mixed findings as to the effects of race and ethnicity. Some researchers have found older Blacks to be more satisfied with their lives. Some have found lower class persons, especially Blacks, to be most happy, adjusted and satisfied. Others cite greater perceived health problems and psychosocial stress as the basis for greater dissatisfaction with life among older Blacks.

Conceptual and methodological problems continue to be offered as reasons for conflicting findings on the determinants of life satisfaction among the elderly, including older Blacks. More research is needed which focuses on the development and testing of conceptual models which examine the interactive effects of multiple variables on mental health and related measures such as life satisfaction.

With regard to the religious factor, we know that many Black older persons are very religious and their religiosity and their involvement in the church seem to mitigate some of the depression and isolation which can be associated with old age.

We know that families play a significant role in the mental health of the older person as well. There are several trends among Black families which I believe have implications for the mental health for present and future cohorts of older Blacks.

First, traditional Black family structures, characterized by extendedness and mutuality, have undergone significant changes in the last several decades. There is some evidence that the influence of modernity in Black Americans has rendered the elderly less able to rely upon blood relatives and fictive kin for affective and instrumental support.

Again, research has been scant on the impact of family reconfiguration on the mental health of the Black elderly. However, there are some suggestive findings.

There was a study that I'll cite by Lassiter. All subjects identified the family as the main source of support in times of stress, followed by the church or other religious groups, themselves and friends as remaining sources of support.

It's very interesting to note, as we look at literature on the elderly, and minority elderly in particular, how little of their support and how few services are actually provided by the formal service system, particularly the mental health system.

With regard to specific patterns of mental illness, there's very little data available on the Black elderly per se with regard to mental illness. Trends observed in the Black population generally indicate an increase in serious clinical depression among all segments of the Black population, but particularly among those with broken marriages, those not employed outside the home, those with lower incomes, and the less well educated.

According to unpublished data from NIMH, Division of Biometry and Epidemiology, inpatient admissions to State and county psychiatric hospitals in 1975 by race, sex, and age revealed that for the 65 and older population, admission rates were much higher for Blacks than for whites, regardless of sex. Outpatient statistics for the same time period revealed even higher rates for elderly Blacks as compared to elderly whites.

Date on the use of mental health facilities in the United States by Blacks and other minorities show that alcoholism and drug disorders are predominantly male and nonwhite problems. Depressive disorders are predominantly female and nonwhite. Schizophrenia is predominantly nonwhite; neuroses are predominantly white and slightly male.

The above summary of diagnostic patterns suffers, to some extent, of problems association with limited data. We know that very often the information you get on patterns of mental illness come from public mental health agencies with reporting requirements. We, therefore, don't know what patterns of mental disorders are being seen by private mental health practitioners.

It has long been known that social class is a determinant of diagnostic classification, diagnostic severity, prognosis, and treatment in mental health. It is relevant to note that the continued tendency to diagnose Blacks and other minorities, including the poor and women, as more seriously ill has been attributed to a variety of factors, including communication problems between patient and provider, subcultural differences regarding what behaviors are viewed as abnormal or unacceptable and institutional racism.

The tendency for Blacks to be more frequently diagnosed as schizophrenic while whites are diagnosed as depressed is of major significance with respect to the elderly.

For example, the psychiatrist James Carter has argued that racism generated adaptations among Blacks which often baffle white mental health professionals.

Seeing such behavioral adaptations as a survival technique with roots in slavery, he argues further that neurotic depression in Blacks is often diagnosed as paranoid schizophrenia. Citing the absence of adequate normative standards which reflect differences in education and culture as the basis for skewedness in psychiatric testing, he argues cogently for the development of psychosomatically sensitive measures.

Much more research will be necessary to fully explain the dynamics of somatic symptoms, which are so common among people with repressed mental conflicts.

Suicide and alcoholism among older Black is something of particular concern to me. I believe that failure to deal with depression in Blacks is probably related to insufficient research on death, dying and suicide in this population. Emphasis on Black elderly deaths, particularly with respect to suicide, is of low priority. This may be partially explained by the recent and rapid increase in suicides among young Blacks as well as the lower suicide rates among older Black males as compared to older white males. Scholars have suggested that racism and sexism are part of the reason for this lack of emphasis.

It is important to mention in this connection that depression has been found to relate significantly to presuicidal ideation and planning, and this is one of the mental illnesses for which Blacks, especially in their later years, are not accurately diagnosed.

Further, alcoholism and alcohol abuse in the elderly suicide is very common. There is considerable evidence that Blacks and Hispanics who drink excessively tend to die from a variety of alcohol

related diseases which reflect the same type of self destruction associated with suicide.

Let me note, very often at research presentations like this, much is made of the difference between rates of suicide among the elderly between Blacks and whites, particularly males. One of the concerns I have is the way in which we define suicide in making that kind of comparison. It would seem to me that an older Black male who is told by his physician that he has severe liver damage and pancreatic damage, and if he continues to drink excessively he is going to kill himself, and if that older male chooses to continue drinking, I don't see his actions as any less an act of suicide than someone putting a gun to his head and pulling the trigger. I think we have significantly more suicidal behavior among Black older males in particular.

I would just like to note briefly a few requirements I believe are needed to improve mental health services for older Blacks. I think that we need a holistic approach in treatment planning. Mental health professionals need to be trained to be much more skillfully in the process of communication with older Black patients.

The communication process between provider and patient colors the entire treatment and service delivery process. There are a number of factors which can hamper communication and the establishment of trust. One of the obvious barriers is language differences. Because the Black elderly are English speaking, there may be an assumption that language barriers are not an issue. This is a widespread and erroneous assumption.

In relating to white service providers, older Blacks are likely to use long established patterns of communication which have helped them to survive in a hostile and oppressive environment. They may feel that they should tell providers what they think they want to hear, rather than what they need to know.

Most importantly, they may be less likely to complain about ineffective treatment and poorly delivered care based on historical experiences which suggest that they may be retaliated against or their complaints will be ignored.

Communication content should focus on obtaining a detailed picture of the older Black person. Information should be gathered on living conditions, family arrangements, exercise and leisure time activities, eating, drinking, and sleeping patterns, degree and sources of emotional stress, economic—not just insurance—status, occupational history and risk exposures in the workplace, past patterns and illness, and health and mental health services utilization.

In addition, efforts should be made to understand the patient's belief system about the causes of the presenting illness, preferred approaches to treatment and other socio-cultural factors which are likely to influence the understanding of and compliance with recommended treatments approaches.

I would like particularly, Chairman Roybal, to compliment you on the bill that you proposed, because I think that the bill addresses the need for increased funding, not only for service delivery and the reduction of financial barriers to services, but also your emphasis on training and research which I hope will begin to identify some of the problem areas that I've outlined.

Thank you very much.

[The prepared statement of Dr. Jones-Morrison follows:]

TESTIMONY OF BARBARA JONES-MORRISON, D.S.W.

Assistant Director, Program Development
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Presented at Hearings Held by the
U.S. House Select Committee on Aging
on Mental Health Needs of the Elderly

May 13,1988
Queens, New York

Chairman Roybal and Members of the U.S. House of Representatives Select Committee on Aging, I am very pleased to have been asked to address the mental health needs of the Black elderly. For several years I have been involved in gerontological research with special attention to the needs of members of racial and ethnic minority groups. My research perspectives have been enhanced by several years of employment in New York State government in the policy and planning arena related to the design and delivery of long term care services for persons with physical and mental disabilities.

I would like to begin with a brief demographic profile of the Black older person in the United States, with special attention to those factors which are likely to increase the prevalence of mental and emotional distress. It is important to remember that there are significant variations on these patterns among the Black elderly. Differences in educational levels, social class, place of origin, and degree of acculturation to "mainstream" norms create substantial diversity at the individual level. Nevertheless, dominant patterns are useful for assessing population-based patterns of risk and need.

Demographic Patterns of the Black Elderly

The gerontological literature indicates that mental illness

among the elderly can be attributed to several factors which characterize the normal aging process. These are increased vulnerability to physical illness, loss of income and self-esteem associated with retirement from the labor force, death of family members and friends, and increased isolation resulting from the shrinking of social networks and opportunities for social interaction.

The Black elderly are especially vulnerable to many of these risk factors. In 1971 the Committee on Aging of the Group for the Advancement of Psychiatry stated, " Being black and aged frequently means the piling up of life problems associated with each characteristic. The black aged often have less education, less income, smaller or no social security income, less adequate medical services, and fewer family supports than the aged in general. . . Racism and "ageism" may be combined to prevent the black aged from getting needed services of all types." (p.21)

Older Blacks will constitute an ever-growing percentage of the Black population and the older population in the United States. They will bring with them into old age many problems which increase their vulnerability to mental illness. The 1980 Census indicated that Blacks over the age of 65 represented 8% of the U.S. population over the age of 65. In 1983 there were 2,226,000 Blacks over the age of 65 in the United States. We

know that very advanced aged is associated with higher incidence of dementia. Life expectancy tables reveal a "cross-over" phenomenon in which Blacks over the age of 75 tend to outlive their white counterparts. If this pattern continues in the future, Blacks will be an increasing percentage of the "old, Old" who are the highest users of long term care for mental and physical disabilities. The most rapidly growing segment of the Black elderly population are women 80 years of age and older.

Familial and Social Supports

The availability of a spouse and children appears to reduce the isolation of old age. Older Black women are much more likely to enter old age as widows or divorcees. In 1983, among all aged persons, only 27% of Black women were married and living with their spouse, as compared to 40% of White women, 63% of Black men, and 78% of White men. (Jackson, 1985) Almost 2/5ths of Black older women did not live in familial households in 1983. Among persons 65-74 years of age, 36.7% of Black women and 35/8% of White women lived alone, as compared to 20% of Black men and only 12% of White men. (Jackson, 1985) On the other hand, Black women are more likely to have had children compared to White women, and the unavailability of spousal support may be offset, to some extent, by the presence of adult children to provide both instrumental and emotional support. The larger numbers of Black older women living alone may have implications for increased vulnerability to isolation and depression.

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Environmental Stressors

More aged Blacks (53%) lived in central cities compared to Whites (27%). The environmental challenges of complex urban living place greater demands on the Black elderly. They are more likely to be victimized by the "gentrification" of inner cities where they are forced to compete with younger (and equally poor) Blacks for scarce affordable housing. As old neighborhoods are destroyed through neglect or urban "development", old support networks are dismantled. The fear of crime among older urban dwellers is well documented. Many Black elderly will not venture out of their homes after dark and they curtail social outings, shopping, and other activities which may place them at increased risk for robbery or assault. Some have become prisoners in their own homes. Service systems in large urban areas are fragmented and difficult to access and negotiate. Many Black elderly allow medical and mental health needs to reach crisis proportions before the severity of the problem forces them to face the challenge of seeking help.

Effects of Poverty

Income levels of older Blacks are the clearest indicators of the effects of historical employment and educational discrimination. In 1981, median income for a single person over the age of 65 years $13,832 for White males, $7,808 for White

females, $8,345 for Black males, and $4,812 for Black females. (U.S. Bureau of the Census, 1983). That older Black women are the poorest of the poor is indisputable. The number of poor aged Blacks who live in female-headed families (where no spouse was present) rose from 302,00 in 1966 to 480,000 in 1983, an increase if 59%. Forty-one percent of older Black women are poor, as compared to 28.3% of Black males, 14.7% of White females, and 8.2% of White males. (Jackson, 1985)

The elderly poor are at increased risk of chronic illness and disability, poor nutrition, inadequate housing,and lack of financial resources to purchase needed items and services. Each of these leads to higher rates of mental and emotional distress.

Physical Health Status and its Effect on Mental Health

The presence of debilitating physical conditions has been shown to be correlated with higher levels of mental distress. The chronically ill are more likely to be depressed and result to the abuse of alcohol or other drugs to self-medicate. Older Blacks show high rates of death and chronic disability due to cancer diabetes, heart disease, stroke, and cirrhosis of the liver as compared to whites of the same age. This is particularly true of the older Black male. (Report of the Task Force on Black and Minority Health, USDHHS, 1985).

Jackson, et. al. (1982) found that among Black elderly, health concerns and levels of stress (as measured by perceived

problem seriousness), were positively correlated. Psychological distress had physical health consequences and vice-versa. The essence of their research indicates that there are multiple dimensions to the concept of mental healthiness and that previous studies have tended to treat the construct as unidimensional, thereby failing to consider and measure the interplay of physical and mental health.

Because the elderly in general, and elderly from racial and ethnic minority groups in particular, are reluctant to define a problem as "mental", they are more likely to "somatize" emotional stress and seek help from medical personnel. Seeking medical attention does not carry the same stigma and shame associated with seeking psychiatric services.

Alcohol Abuse

Heavy use of alcohol is also a mask for depression in the elderly. Information is sparse on specific drinking patterns among the Black elderly. There is some research that shows that Black males report higher rates of heavy drinking after age 30, compared to White males where problem drinking seems to be concentrated in the 18-25 year age group. (USDHHSD, 1985) Mortality rates from cirrhosis of the liver have declined consistently among all race-sex groups since 1973, but they remain disproportionately high for Black Americans. This would indicate that alcohol abuse remains a significant health and mental health problem among Blacks.

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MENTAL HEALTH AND MENTAL ILLNESS AMONG THE BLACK ELDERLY

The focus on Black psychological well-being emerged largely from the psychology of oppression literature of the 1950's when it was suggested that all Blacks carried the "mark of oppression" and were, therefore, psychologically unhealthy (Kardiner and Ovesey, 1951). These authors stimulated much theoretical and empirical writing on the strengths and adaptiveness of Black behavior (Gresson, 1982; Jones, 1982) In the emerging literature, the Black elderly were portrayed as displaying great psychic and physical resilience in the face of overwhelming oppression, but there was really no serious inquiry into the personal well-being and psychological adjustment of the Black elderly (Jackson, 1979).

Recently, this state of affairs has changed as scholars have begun to consider Black mental health and adjustment, particularly how group status and group membership impact the subjective sense of well-being (James Jackson, et. al., 1979; 1982). As James Jackson and his colleagues at the University of Michigan's Survey Research Center point out:

> More recent work . . . focuses on mental health and illness issues of the elderly in a multi-faceted perspective. There is a great concern for mental health both as the absence of specific disease states and as the presence of a positive sense of self and generally positive view of personal well being . . .

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> This multi-dimensional and multi-faceted view of mental illness and mental health is certainly appropriate in an examination of the mental status of Black Americans. As an oppressed minority, many of their mental health problems are as much, if not more a function of environment than the outcome of intra-psychic conflict .

The emphasis on environmentally produced stress as a biopsychosocial predictor of mental illness is a decisive breakthrough in the Black mental health literature. In 1969, the President's Commission on Mental Health stated:

> . . . the racist attitude of Americans which causes and perpetuates tension is patently a most compelling health hazard. Its destructive effects severely cripple the growth and development of millions of our citizens, young and old alike. Yearly, it directly causes more fatalities, disabilities, and economic losses than any other factor. (p. 823)

Similarly, the Subpanel on Mental Health of Black Americans of the President's Commission on Mental Health (1983) wrote, " it is largely the environment created by institutional racism, rather than intrapsychic deficiencies in Black Americans as a group, that is responsible for the overrepresentation of blacks among the mentally disabled." (p.823) As a subset of the Black population, the Black elderly are subject to environmental stressors to which they have adapted over a lifetime. When they

do seek help for problems they encounter in adjusting, they are likely to experience forces common to most Blacks with similar needs. Orlando Lightfoot (1982) explains:

> Black elderly persons, presenting themselves in a biopsychosocial dilemma, must risk experiencing what all other blacks do, including (1) negative stereotypes, (2) diminished access to psychiatric services, and (3) limited professional resources. (p.216)

In view of the emphasis on environmentally induced stress, I will consider some of the major themes related to Black elderly well-being and external sources of psychological distress in this population.

Psychological Well-Being and Life Satisfaction

The essential question concerning many with respect to minority elderly is how do they view and experience "psychological aging"? (Jackson, 1980). The "psychological aging" process includes adaptation to both the normal and abnormal problems of aging, including cognitive impairment, biological changes such as insomnia or sensory deficits to which adjustments must be made, and psychiatric problems such as depression, paranoia, anxiety, and suicidal ideation.

Research has indicated that variables such as ethnicity, sex, and class are related to how people perceive and adjust to their own aging. For example, Chicanos tend to see themselves as aging sooner than Blacks and Anglos (Miranda and Ruiz, 1981).

Similar findings with respect to Black elderly have been less definitive. The infantilization of Blacks that occurred during slavery lead to the stereotypic notion that Blacks (even the elderly) were child-like and happy, and incapable of experiencing the depression and affective disorders experienced by Whites. Although this type of thinking has diminished over time, stereotypes and myths die hard and vestiges of this attitude remain among the general population, including health care providers.

The research on minority aging has, in part, focused on tempering these stereotypes by examining self-perceived and self-reported perceptions of aging and life satisfaction among older Blacks. Jacquelyne Jackson (1980) states:

> Some years ago I reported studies showing that blacks tended to define themselves as being old at earlier chronological points than did whites. I felt this was realistic in light of the fact that blacks were often older earlier than whites, as measured by their physiological and social age. Since then Betram Walls and I examined some of the data from the 1974 Harris Survey of aging and found that two results pertinent here. First, a majority of aging Blacks, as other aging persons, employed a functional, not a chronological, definition of old age. Old age is increasingly being equated with the inability to maintain personal care. Second, no racial differences were apparent among black and white subjects defining old age chronologically. Thus, it seems to be increasingly true that race is not an influential variable determining definitions of old age. (pp. 108-109)

What this statement suggests is that functional status, as a

reflection of underlying health and disability, determines when a person feels physically and psychologically "old" regardless of actual chronological age. Thus, efforts to assess the perceived or actual mental health of an older person, must include attention to functional status. The evolving literature on perceived life satisfaction, also supports this view.

Life Satisfaction

The research on life satisfaction has produced mixed findings as to the effects of race and ethnicity. Some researchers have found older Blacks to be more satisfied with their lives. Some have found lower class persons, especially Blacks to be most happy, adjusted and satisfied. Others cite greater perceived health problems and psychosocial stress as the basis for greater dissatisfaction with life among older Blacks. Jacquelyne Jackson (1980), using the 1974 Harris Survey data found, "very important is the fact that life satisfaction scores of high-income aged blacks exceeded those of low-income aged whites, thereby suggesting that socioeconomic status plays some role in influencing life satisfaction." (p.109)

James Jackson and his colleagues (1982) at the University of Michigan offer a hypothetical explanation from their own research for the conflicting findings on race and life satisfaction:

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> Given the growing heterogeneity in previous life cycle experiences of the black elderly as represented in the present sample, the lack of a definitive pattern of relationships among socio-economic and measures of psychological distress and global well-being is not unexpected. (p.32)

Conceptual and methodological problems continue to be offered as reasons for conflicting findings on the determinants of life satisfaction among the elderly, including older Blacks./ Similar issues pertain to the broader study of mental health and mental illness among Blacks. /More research is needed which focuses on the development and testing of conceptual models which examine the interactive effects of multiple variables on mental health and related measures such as life satisfaction./ Some steps are being taken in this direction.

For example, a recent study on stress and racial differences in self-reported health among Black and White elderly (Kruse, 1987) reported that, " . . . chronic financial strain was strongly related to the health of older whites, but not older blacks. . . . . Network crises have a significant impact on the health of older blacks not on older whites. More specifically, the data indicated that more network crisis events are associated with worse health among Blacks. [emphasis added] (pp.74-75) The author found the relative benefits and costs of inter-generational exchange the most compelling explanation for this

finding. Krause states that, " If it is true that receiving social support entails reciprocity and greater involvement in the lives of others, it is possible to explain why network crises events affect older blacks, but not older whites." (p. 76)

Other studies have suggested that Black older women, in particular, are other-directed and tend to define themselves in terms of their relatedness to others. This theme, while not fully developed in the literature on women in their later years, is addressed in such works as Gilligan (1980) In a Different Voice and Elaine Brody's numerous writings on intergenerational family relationships.

The Religious Factor

As with life satisfaction and perception of aging, researchers concerned with the relative importance of religion as a determinant of mental health among elderly from different racial and ethnic groups have produced mixed findings. For example, Maurice Jackson and James Woods (1976) argued that Blacks attached comparatively greater importance to religion than whites, but Jacquelyne Jackson (1980) has argued that racial differences are inconclusive, in part, because of the failure to control for differences in social class. She concluded that more research in this area needs to be conducted.

What does seem established in the minds of some, however, is that religion is traditionally significant for the psychological

well-being of Blacks, especially the elderly. Myers (1982) reported preliminary evidence regarding the relationship between supports provided through the church and the maintenance of mental health in the face of race, gender, and age-related stresses. Her interviews with Black elderly women in Mississippi revealed that religion and the religious network is a critical component of their coping styles.

Other Factors Affecting Mental Health

In a study based on a national probability sample of Black elderly, James Jackson and his colleagues (1982) examined the relationship of well being and problem seriousness among 2,107 Black elderly persons with respect to different demographic characteristics. They report:

> . . . our investigation of the relationship of important demographic and background variables (marital status, age, education, income, and health satisfaction) to mental health measures indicates that both global well-being and problem seriousness differ as a function of important socio-economic groupings . . . our results suggest that there are meaningful and important differences among the diverse and heterogeneous demographic groups of black aged . . . .
>
> Thus we might note that there was a basis for the recent finding that married persons reported themselves more favorably than nonmarried; higher income positively related to lower levels of serious problems, with high school graduates being the least happy with their lives. Higher education was also positively related to less serious problems. However, there have been conflictive results among studies regarding this relationship among SES

> variables such as income, education, psychological distress, and global well-being: some findings indicate a positive and others indicate no relationship among these factors. (p.32)

Family and Mental Health

Cantor (1976), Bengston and Bantu (1980) have considered family size, family structure, and traditional beliefs and values as they impact on mental health. The family, both nuclear and extended, has long been seen as critical to the development and overall mental health of the Black person through the life cycle (Billingsley, 1968; Barnes, 1972; Hill 1972).

There are several trends among Black families which we believe have implications for the mental health for present and future cohorts of older Blacks. First, traditional Black family structures, characterized by extendedness and mutuality, have undergone significant changes in the last several decades. There is some evidence that the influence of modernity in Black Americans has rendered the elderly less able to rely upon blood relatives and fictive-kin for affective and instrumental support. (McAdoo, 1981; Morrison,1983) Again, research has been scant on the impact of family reconfiguration on the mental health of the Black elderly. However, there are some suggestive findings. Lassiter (1987), for example, conducted intensive interviews with 51 Black American and Black West Indian elderly in New York City. Among her findings were that Black Americans generally advocated more traditional values and family beliefs than did their West

Indian counterparts. All subjects, however, identified the family as the main source of support in times of stress, followed by the church or other religious group, themselves, and friends as remaining sources of support. The author concludes that, " The family serves as the major support mechanism for Black individuals, especially for Afro-Americans. Health providers should utilize family members as significant others in health assessment, planning, and therapy." (p.28)

Taylor and Chatters (1986) observed similar reliance on informal networks based on data from a national survey of Black Americans. However, their subjects reported receiving less support from family than from friends. They explained this finding by the decrease in the size of kin networks (especially of spouse and siblings) as age advances and differences in the sources for specific types of support.

Psychological Distress and Elderly Blacks

Various scholars have documented racism as a mental health problem (Gresson, 1978, 1982; Lightfoot, 1982; Poussaint, 1983; Thomas and Sillen, 1972). Indeed, Blackness as an expression of devalued racial identity within Western society has generated a massive literature documenting the internal and external sources of stress and adaptation which may result in both acute and chronic mental illness.

What this literature also suggests is that the identification, classification, and measurement of mental illness among Blacks are also tied to the structure of the dominant White society and the place of Blacks within it. It has become popular to suggest that Blacks have learned to survive so well under conditions of oppression, that in old age they do not suffer the types of losses which lead to the suicidal patterns of elderly White males. Or if they do experience such losses, they are somehow not as psychically disruptive. The literature on this subject is mixed. There have been those studies which find Black elderly to fair emotionally better in old age as compared to Whites, and those which continue to find increasing deprivations and despairing prognoses. It is against this backdrop that I examine the major themes in the literature on psychopathology among older Blacks.

Incidence and Prevalence

Very little data are available on the Black elderly per se with regard to mental illness. Trends observed in the Black population generally indicate an increase in "serious (non-clinical) psychological depression among all segments of the Black population, but particularly among those with broken marriages, those not employed outside the home, those with lower incomes, and the less well-educated . . . .(Poussaint, 1983, p. 229).

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According to unpublished data from NIMH, Division of Biometry and Epidemiology, inpatient admissions to State and County psychiatric hospitals in 1975 by race, sex, and age revealed that for the 65 + age cohort, admission rates per 100 000 population were as follows: 130.9 for White males, 54.0 for White females, 210.8 for Black males, and 143.7 for Black females. (Poussaint, 1983, p.231) Outpatient statistics for the same time period revealed even higher rates for elderly Blacks as compared to elderly Whites: 129.2 for White males, 278.9 for White females; 132.9 for Black males, and 735.0 for Black females.

Data on the use of mental health facilities in the United States by Blacks and other minorities show that, " Alcoholism and drug disorders are predominantly male and nonwhite problems. Depressive disorders are predominantly female and nonwhite. Schizophrenia is predominantly nonwhite; neuroses are predominantly white and slightly male. Childhood disorders are nonwhite and male; and social maladjustment is predominantly nonwhite and female (Health Status of Minorities and Low Income Groups, p. 157)

Diagnostic Bias

The above summary of diagnostic patterns suffers from problems associated with limited data sources. In addition,

available data sources are biased toward characterization of poor and minority populations who use public mental health services with reporting requirements.

It has long been known that social class is a determinant of diagnostic classification, diagnostic severity, prognosis, and treatment in mental health (Hollingshead and Redlich, 1958; Scheff,1966). It is relevant to note that the continued tendency to diagnose Blacks and other minorities, including the poor and women, as more seriously ill has been attributed to a variety of factors: communication problems between patient and provider (Cannon and Locke, 1976); subcultural differences regarding what behaviors are viewed as abnormal or unacceptable (Williams, 1982); and institutional racism (Sabshin, Diesenhaus, and Wilkerson, 1970).

The tendency for Blacks to be more frequently diagnosed as schizophrenic while Whites are diagnosed as depressed is of major significance with respect to the elderly. For example, Carter (1974) has argued that racism generated adaptations among Blacks which baffle mental health professionals. Seeing such behavioral adaptations as a survival technique with roots in slavery, he argues further that neurotic depression in Blacks is often diagnosed as paranoid schizophrenia. Citing the absence of adequate normative standards which reflect differences in education and culture as the basis for skewedness in psychiatric testing, he argues cogently for the development of

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psychosomatically sensitive measures:

> After reviewing the records and working with a large group of black patients enrolled in the Lincoln Comprehensive Health Center, a federally funded community-based health program in Durham, North Carolina, I have concluded that the most common clinical findings related to neurotic depressions are multiple somatic symptoms. The pioneer work of Leighton called attention to the significant relationship between pscyhosomatic symptoms and cultural origin. Many explanations have been offered for the dynamics of the psychosomatic expressions of emotional illness in blacks, but to date most seem incomplete.
>
> Much more research will be necessary to fully explain the dynamics of somatic symptoms, which are so common among repressed people with repressed mental conflicts . . . mental health professionals in the field of geriatrics should be expanding and refining the definitions of mental illness and psychologic treatment for the black patient. This involves many things, but seems to begin with correcting mistaken attitudes about blacks and the myth that they are seldom, if ever, depressed. (1977, p.207)

Suicide and Alcoholism in Older Blacks

Failure to deal with depression in Blacks is probably related to isufficient research on death, dying, and suicide in this population (Davis, 1982). Emphasis on Black elderly deaths, particularly with respect to suicide, is of low priority. This may be partially explained by the recent and rapid increase in suicides among young Blacks, as well as the lower suicide rates among older Black males as compared to older White males. Scholars have suggested that racism and sexism are a part of the

reason for this lack of emphasis (David, 1982; Miller, 1979). For example, Lee, West and Murphy (1977) have found that among lower class Black and White psychiatric and medical patients six variables distinguished suicidal from nonsuicidal patients and Blacks from Whites: degree of social integration, knowledge of or relationship to a suicide attempter or completer, attitude toward aging, secular attitudes, alcohol-induced brain damage, and depressive illness.

It is important to mention in this connection that depression has been found to relate significantly to pre-suicidal ideation and planning (Miller, 1979) and this is one of mental illnesses for which Blacks, especially in the later years, are not accurately diagnosed. Further, alcoholism and alcohol abuse in the elderly suicide is very common. There is considerable evidence that Blacks and Hispanics who drink excessively tend to die from a variety of alcohol-related diseases which reflect the type of self-destruction associated with suicide. This is suggestive of a curious connection between young Black male suicides (who tend to be drunk when they commit this act) and those men who reach age sixty, but die from alcohol-related diseases. Davis (1982) seems to appreciate this interplay in his advice to mental health planners:

> On a larger scale, mental health planners who recognize the rapid rise in suicide among young blacks may find this perspective of social context useful in designing mental health

> policies and programs to reinforce and contribute to the well-being of predominantly black communities . . . . The planners should also seek to understand the extragroup indicators relating to employment and income. These indicators and the negative ones related to ill health, mental illness, and substance abuse, reflect the degree of social functioning or dysfunctioning of members in predominantly black communities. (pp. 312-313)

Finally, the incidence and prevalence of mental illness among older Blacks appears to be related to powerlessness as determined by sex and race:

> Perhaps the safest speculation that can be made from the extremely limited information about sex differences among racial minorities is that aged women tend to be at higer risk than aged men for psychological problems, due largely to their inferior status. That is, the incidence and prevalence of psychological and psychiatric problems not organically induced are inversely related to power, prestige, and economic statuses . . .
> (Jackson, 1981, p.107)

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New York State Office of Mental Health

REQUIREMENTS NEEDED TO IMPROVE MENTAL HEALTH SERVICES DELIVERY TO OLDER BLACKS

Holistic Assessment and Treatment Planning

The biopsychosocial framework calls for an holistic approach to the assessment of wellness and illness in older Blacks. At the clinical (micro) level, mental health professionals must be trained to effectively communicate with their older Black patients so as to elicit reliable information on those factors in the patient's life sphere which are key determinants of mental health status. This calls for attention to both communication process and communication content needed to make a comprehensive assessment as the first step in the treatment process.

The communication process between provider and patient colors the entire treatment and service delivery process. There are a number of factors which can hamper communication and the establishment of trust. One of the obvious barriers is language differences. Because the Black American elderly are English-speaking, there may be an assumption that language barriers are not an issue. This is a widespread and erroneous assumption.

In relating to White service providers, older Blacks are likely to use long-established patterns of communication which have helped them to survive in a hostile and oppressive

environment. They may not be trusting enough to be completely candid about problems and their sources. They may feel that they should tell providers what they think they want to hear, rather than what they need to know. They will be especially sensitive to any form of communication (verbal or non-verbal) which appears to diminish their self-esteem. (For example, the use of first names without approval or hesitancy in making physical contact with the patient). Most importantly, they may be less likely to complain about ineffective treatment and poorly delivered care based on historical experiences which suggest that they may be retaliated against or their complaints will be ignored.

In communicating with older Blacks it is essential that mental health professionals convey an attitude of nonjudgmental understanding of behaviors, even as they seek to change those which negatively impact on the health of the older person. Change should be fostered through education, not castigation. Professionals will also need to engage in a process of self-examination whereby they attempt to scrutinize their own feelings toward the older Black person and how these feelings are conveyed in the provider-patient relationship.

Communication content should focus on obtaining a detailed picture of the older Black person _in situ._ Information should be gathered on living conditions, family arrangements, exercise

and leisure time activities, eating, drinking and sleeping patterns, degree and sources of emotional stress, economic (not just insurance) status, occupational history and risk exposures in the workplace, past patterns of illness, and health and mental health services utilization. In additional, efforts should be made to understand the patient's belief system about the causes of the presenting illness, preferred approaches to treatment (including the use of traditional healers), and other socio-cultural factors which are likely to influence the understanding of and compliance with recommended treatments approaches.

A comprehensive assessment of social, familial, and psychological, as well as physical functioning, will allow the mental health professional to identify possible points of intervention in all of these areas. A multi-disciplinary team approach to assessment and treatment should prove useful in working with older Black patients, as it has for older patients in general.

Networking

Mental health professionals must be trained to use existing social networks of the elderly, to implement treatment activities. For older Blacks, these networks include family groups, churches, social clubs such as fraternities and sororities, senior centers, tenants of senior housing or any

other collectivity of which the older person feels a part. Degree of participation in social networks can be ascertained during the comprehensive assessment.

Advocacy and Case Management

Patterns of mental health services utilization indicate that there are access barriers for older Blacks. Barriers exist because services may be lacking altogether, they may be located in areas which make them difficult to get to, there may be financial barriers, or older Blacks may be victims of class and racially biased referral and admissions policies which limit their access to scarce health and mental health resources. In order to overcome these barriers, older Blacks need the assistance of health professionals. That assistance is in the form of advocacy and case management.

Advocacy skills development should be part of professional training. In requires that health professionals understand the historical, social, political, and economic factors which are frequently the foundation for ageist, racist, and class biased policies and practices in health care.

Advocacy takes place on multiple levels. Practitioners can advocate for individual elderly Black clients on a case by case basis, but they should also be encouraged and trained to become advocates in larger political arenas in which health and mental

health priorities and policies are established. On the individual client level, advocacy is a key component of case management. Case management requires that the strengths and needs of the older Black person be comprehensively assessed, a plan be developed to provide needed care and services, and steps taken to assure that planned services are actually delivered in an efficient and culturally appropriate manner. It is the third step of the process which requires advocacy.

Advocacy at the macro level requires action not only in the domain of health and mental health care, but in other service arenas such as income maintenance, Social Security, Older Americans Act programs, employment, and housing where policies are made which directly determine the living conditions of older Blacks and indirectly determines health and mental health status.

Implications for Research and Service Delivery

Trend Analyses for Future Cohorts of Black Elderly

A lifetime of poor health and health care leaves its most visible legacy in the old. There are trends in the life situations of some segments of young and middle-aged Blacks which foretell problems for future cohorts of Black elderly. Among these are low educational levels due to high drop-out rates,

higher levels of unemployment and underemployment; increasing rates of poverty, and family dissolution. These factors will act to increase the risk of physical and mental illness, while decreasing available resources to prevent and cope with health problems.

More longitudinal studies of Blacks as they age need to be conducted. During the course of these multi-year studies, data should be used to suggest courses of corrective action which can be implemented in the interim to reduce risk of future mental and physical disability. The interplay of socio-economic factors and health status should be the focus of investigation.

Heterogeneity and Within-Group Differences

All Blacks are not alike. All Black older people are not alike. Professional training would be enhanced by an appreciation of patterns of heterogeneity among Blacks, including the elderly.

There needs to be more research into the effects of factors such as economic status, educational level, spirituality and religiosity, degree of acculturation into the "main stream", and differences in life style among Blacks as they relate to health and mental health. While comparisons between Blacks and Whites or between Blacks and other ethnic/racial groups are useful, they do not usually provide the depth of analysis on other variables which determine differences in well-being between Black people.

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New York State Office of Mental Health

Provider-Patient Relationship

There has been much research on the importance of the relationship between the health and mental health care provider and the patient. In particular, the quality of communication has been of special interest. Yet, there is little research which focuses on provider-patient communication specifically for older Blacks.

How are variables such as diagnostic accuracy, treatment approach, patient compliance, patient education, and service utilization affected by the "quality" of the relationship between the older Black person and the health care provider? What factors appear to make for a better relationship? Do class, economic, educational, and age differences or similarities make a difference ? Are these more or less important than cultural or racial differences or similarities between patient and provider?

Traditional Health Practices

There is a body of literature, primarily from sociology and anthropology, which describes "traditional" health beliefs and practices among different racial and cultural groups. More information on the prevalence and nature of such beliefs and behaviors among older Blacks is needed. In addition, the longitudinal studies of younger and middle-aged Blacks previously noted, would help to assess the degree to which traditional

individuals are less likely to have a voice in major policy and program decisions, their interests must be especially protected.

An example of such impact studies might relate to policies being considered such as raising the Social Security and Medicare entitlement age. What will this mean to elderly Blacks whose life expectancies are shorter? How would any resulting reduction in income and insurance coverage effect their health status and mental health and ability to access needed care?

Impact of the Proposed Legislation

The provisions in Chairman Roybal's proposed legislation Elderly Mental Health Services Development and Reform Act of 1988, will help to address the issues raised in this analysis. The particular emphasis on attention to the needs of elderly mentally ill who are members of racial and ethnic minority groups is laudable. The specific provisions for increased funding for professional training and research will help implement training programs and research projects which will enhance the ability of mental health professionals to more effectively serve the minority aged who are mentally ill. Modifications in reimbursement provisions under Medicare and Medicaid should help to reduce the fiscal barriers to accessing needed services for the Black elderly who are so overrepresented among the poor.

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The CHAIRMAN. The Chair will now recognize Ms. Martha Sullivan. You may proceed.

STATEMENT OF MARTHA ADAMS SULLIVAN, CSW, ASSISTANT DIRECTOR OF PSYCHIATRY, AND DIRECTOR, CENTER FOR OLDER ADULTS AND THEIR FAMILIES, GOUVERNEUR DIAGNOSTIC AND TREATMENT CENTER, NEW YORK, NY

Ms. SULLIVAN. Mr. Chairman, and members of the Select Committee, I'm Martha Adams Sullivan, assistant director of psychiatry at Gouverneur Diagnostic and Treatment Center, a Health and Hospital Corporation facility, and chairperson of the Manhattan Geriatrics Committee. I am pleased to present this testimony to you as one who is also a practitioner who provides clinical services for the elderly.

We cannot address the mental health needs of the Black elderly without recognizing the unequal access to all the goods and services of our society which they have too often experienced throughout life. Indeed, a future oriented plan will address these realities of being Black in our society at any age, so that future generations of Black elderly will be able to enter old age with the expectation of living out their later days in circumstances which are more conducive to positive mental health.

People reach old age with a variety of behaviors, coping styles and ways of being which have evolved over time as they negotiate the particular environments presented them and which are maintained by their present circumstances. While ethnic differences result from shared historical experiences among members of a group, there is always room for difference between members of an ethnic or racial group based upon the uniqueness of the individual and factors such as social class, gender, et cetera. One reality of being Black and old in the United States is the greater likelihood of being poor. Nationally, "almost two thirds of Black women aged 85 and older who live alone are poor." In 1986, only one of every nine elderly whites was poor, but more than one of every three Black elderly were poor. If this ratio is applied to the almost 192,000 elderly Blacks age 60 and over living in New York City, then 64,000 of them are living here in poverty. Of course, this does not include those 'near poverty'. I am addressing the needs of the poor and the near poor, mindful that the Black elderly represent a diverse group.

Poverty, for these Black elderly, is unfortunately not a new phenomenon encountered in old age but an exacerbation of a problem of existence in their younger years. In fact, their younger years are also characterized by having had less education, less adequate housing, poorer nutrition and poorer health. These inequalities stem from the fact that, and I quote Nellie Tate:

"The special history of Blacks has been dominated by slavery and its aftermath, segregation. It has involved exploitation and periodic conflict. Moreover, it has mandated subordinated roles and relationships with the dominant group that persist in varying forms today."

This history means that the environment of the dominant society has appropriately been perceived as a hostile, rejecting one. This

legacy must also include the norms retained from an earlier history of African traditions including the centrality of the family and an extended concept of the family, patriarchy, a strong religious sense and an emphasis upon mutual responsibility.

Patriarchal forms of family organization were greatly eroded by the slavery experience but not to the extent of developing a Black matriarchy. Performing both men's and women's duties during slavery brought lower, not higher status to women. Also, women remained the victims of sexual abuse and were treated as sexual objects.

Thus, a basic reliance on the self which incorporates family and community became an important means of copying with a hostile environment. The Black community was represented by a significant network of organizations such as churches, schools, homes for the elderly, orphanages, et cetera, which composed the formal Black helping network.

Urbanization was one of the factors that proved overwhelming to the self help tradition originally based mainly in the rural south and it presented a value conflict as secularism, individualism and competition dominated urban life in the cities of the north during the great migration.

This legacy is of major significance in understanding the Black elderly's use of and access to mental health services. We know, for example, depression is a major mental health problem for the elderly. While the general elderly population may avoid mental health services because of the stigma attached to receiving services, older Blacks may be even less likely to seek out these services due to; one, a lack of knowledge about what mental health treatment or therapy is; two, a lack of knowledge about where resources are when they do exist; and three, a lack of experience, particularly positive experience with formal organizations providing these services.

Service organizations may have been perceived as either intrusive or rejecting. Closer to traditional values than the elderly's urbanized offspring may be, they remain more comfortable relying upon religion and traditional informal systems of mutual aid to relieve emotional as well as concrete problems.

The cathartic religious experience and socialization at church on Sunday may actually prove therapeutic in some instances. That is, if one has the necessary clothing, carfare and assistance to get to church and one is physically well enough to make the trip. Praying on it may also help.

However, when more severe symptoms develop or when the extended family network is geographically distant or is itself overtaxed by problems of poverty, substandard housing, physical or mental illness, et cetera, situations all too common for the Black elderly person today, outside intervention is crucial.

Of course, specialized geriatric mental health services must exist, first of all, and exist in the communities where the Black elderly reside. In New York City, as in the Nation, the geriatric population is grossly underserved with respect to mental health.

Here in Manhattan, the Manhattan Geriatrics Committee and the New York City Department of Mental Health have identified priority service areas based on their high density of elderly, of el-

derly living alone and their limited mental health services. Significant numbers of Black and other minority elderly reside in these areas.

Once services exist, they must be affordable. It is imperative that Medicare begin to cover the costs of mental health care more adequately. The proposed legislation is an important step in this direction. However, 20 visits annually may not address the needs of the chronically mentally ill elderly who require, for instance, day treatment for an extended period or who may require other supportive clinical services indefinitely.

To engage Black elderly in need, various forms of outreach are required. These can take the form of providing community education about services and about geriatric mental health to churches, neighborhood senior centers, medical clinics and social organizations which Black elderly frequent. Outreach can also extend between levels on the continuum of care.

For example, the referral process can include direct contact with a representative of the new agency on-site at the referring agency prior to discharge.

The provision of concrete services should not be overlooked in mental health care. As a first step, tackling concrete needs is a way of meeting clients where they're 'at' and helping them to be more available and comfortable to work on other issues.

Nursing home residents, the homebound, and shelter residents are special subgroups whose mental health needs must also be addressed.

Providing a continuum of mental health care requires the provision of mental health services for nursing home residents. In some instances, able residents might also benefit from participating in psycho geriatric programs offered in the community if Medicaid disincentives were removed.

In home treatment should be provided not only as crisis intervention but as on going treatment for Black elderly whose physical or mental state renders them homebound. There is a sizable group of elderly for example, both Black and non-Black who are living alone often in public housing and who exhibit paranoid symptoms and other behaviors which greatly distress them and those around them and who will not seek any type of service including physical health care. However, they often will accept treatment if it is brought to them.

It was estimated that in New York City in 1976, 24 percent of the homeless women were age 55 and older. Again, this group is disproportionately Black. Often, they have psychiatric admission histories or present mild organic mental disorder.

On site assessments and supportive services for the elderly in shelters need to be expanded.

What about servicing older Black men? Though their numbers are fewer, they too have mental health needs. Widowers in particular may require an array of services and yet have great difficulty accepting these from strangers when family are unable to do for them.

However, true access requires more than developing services and getting people enrolled in them. How can we optimize the Black elderly's use of mental health services both quantitatively and quali-

tatively? We must acknowledge that in addition to all that they share in common with all elderly, the Black elderly have a different, not deviant, but different experience of living and being with impacts their experience of aging.

For example, it is commonly held that older Black women adjust more easily to the loss of a husband because they have shared more equally with men the responsibilities of managing a household throughout marriage. While this adjustment may be true in concrete terms, clinicians must be aware that her seeming adjustment in some areas may overshadow a heightened sense of powerlessness or loss of control over her life which she cannot recognize or articulate. Her, "I can do it all, I've got it under control", posture is not just an individual style but is a role carved out for Black women which is reinforced by her social context. It is important that the concept of the team approach, so widely accepted in the field today come to include not only interdisciplinary care but culturally relevant care.

Black geriatricians in the mental health professions need to be a part of this team to aid the articulation of these important nuances. The existence of Black professionals at all levels of the service unit can also increase the client's sense of trust in the organization and therefore, their willingness to accept the service.

Most importantly, mental health services for the Black elderly need to intervene in their social network, that is family, friends, neighbors, ministers, home attendants or whoever the significant others are. Services must be comprehensive, to address the variety of needs the families may present.

However, a plan to significantly and positively impact the mental health of Black, elderly people, must simultaneously address their poverty and unequal access to opportunity at all stages of life.

Thank you.

[The prepared statement of Ms. Sullivan follows:]

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Mental Health Services for the Black Elderly: Barriers and Needs

Testimony Presented before the U.S. House of Representatives
Select Committee on Aging

May 13, 1988

By

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INTRODUCTION

Mr. Chairman and members of the Select Committee. I am Martha Adams Sullivan, Assistant Director of Psychiatry at Gouverneur Hospital, a Health and Hospitals Corporation facility and Chairperson of the Manhattan Geriatrics Committee - I am pleased to present this testimony to you as one who is also a practitioner who provides clinical services for the elderly.

We can not address the mental health needs of the Black elderly without recognizing the unequal access to all the goods and services of our society which they have too often experienced throughout life. Indeed, a future oriented plan will address these realities of being Black in our society at any age, so that future generations of Black elderly will be able to enter old age with the expectation of living out their later days in circumstances which are more conducive to positive mental health. For example, a disproportionate number of the homeless in New York City are Black. - (According to Garrett and Bahr (1973) forty-four percent of homeless women and 25% of homeless men in New York City were Black). If they survive to old age, what mental state should we expect them to have?

I prefer a broader more ecological definition of mental health - one that considers mental health to be more than the mere absence of disease but the ability to interact effectively with one's environment, performing appropriate social roles and the necessary tasks of daily living (Morrison, 1983 p. 161).

People reach old age with a variety of behaviors, coping styles and ways of being which have evolved over time as they negotiate the particular environments presented them and which are maintained by their present circumstances. While ethnic differences result from shared historical experiences among members of a group, there is always room for difference between members of an ethnic or racial group based upon the uniqueness of the individual and factors such as social class, gender, etc. One reality of being Black and old in the U.S. is the greater likelihood of being poor. Nationally, "almost two thirds of Black women aged 85 and older who live alone are poor". (The Commonwealth Fund Commission, 1987, p. 1). In 1986, only one of every nine elderly Whites was poor but more -

than one of every three Black elderly were poor. (AARP, 1987, p.4). If this ratio is applied to the almost 192,000 elderly Blacks (age 60 and over) living in New York City, (in 1984) then 64,000 of them are living here in poverty. Of course, this does not include those 'near poverty'. (NYCDFTA, 1980, p. 2). I am addressing the needs of the poor and the near poor, mindful that 'the Black elderly' represent a diverse group.

Poverty, for these Black elderly, is unfortunately, not a new phenomenon encountered in old age but an exacerbation of a problem of exsistence in their younger years. (Bengtson, 1979, p. 21). In fact, their younger years are also characterized by having had less education, less adequate housing, poorer nutrition and poorer health. The accumulation of these "poverty-related stressors produces shorter life expectancies". (Varghese, 1979, p. 100). These inequalities stem from the fact that:

> "The special history of Blacks has been dominated by slavery and its aftermath, segregation. It has involved exploitation and periodic conflict. Moreover, it has mandated subordinated roles and relationships with the dominant group that persist in varying forms today". (Tate, p. 96).

This history means that the environment of the dominant society has appropriately been perceived as a hostile, rejecting one. This legacy must also include the norms retained from an earlier history of African traditions including the centrality of the family and an extended concept of the family, patriarchy, a strong religious sense and an emphasis upon mutual resporsibility. According to John Mbiti:

> ...the cardinal point of African philosophy could be summariezed in the saying: "I am, because we are; and since we are, therefore I am," which means that traditional Africans did not see themselves as individuals with a concern for self over the group, but see the group as a corporate part of the individual personality". (Martin & Martin, 1985, p. 12).

Patriarchal forms of family organization were greatly eroded by the slavery experience but not to the extent of developing a Black matriarchy. Performing both men's and women's duties during slavery brought lower, not higher status to women. Also, women remained the victims of sexual abuse and were treated as sexual objects.

Thus, a basic reliance on the self which incorporates family and community became an important means of coping with a hostile environment. The Black community was represented by a significant network of organizations such as churches, schools, homes for the elderly, orphanages, etc. which composed the formal Black helping network.

Several factors have been attributed to the decline of the Black helping tradition: the Great Depression, desegregation, and increased urbanization of Blacks. (Martin and Martin, 1985, p. 63). Urbanization proved overwhelming to the self help tradition based mainly in the rural South and it presented a value conflict as secularism, individualism and competition dominated urban life in the cities of the North during the Great Migration.

This legacy is of major significance in understanding the Black elderly's use of and access to mental health services. We know, for example, depression is a major mental health problem for the elderly. While the general elderly population may avoid mental health services because of the stigma attached to receiving services, older Blacks may be even less likely to seek out these services due to: (1) a lack of knowledge about what mental health 'treatment' or 'therapy' is, (2) a lack of knowledge about where resources are when they do exist and (3) a lack of experience, particularly positive experience with formal organizations providing these services. 'Service' organizations may have been

perceived as either intrusive or rejecting. Closer to traditional values than the elderly's urbanized offspring may be, they remain more comfortable relying upon religion and traditional informal systems of mutual aid to relieve emotional as well as concrete problems. The cathartic religious experience and socialization at church on Sunday may actually prove therapeutic in some instances. That is, if one has the necessary clothing, carfare and assistance to get to church and one is physically well enough to make the trip. "Praying on it" may also help. However, when more severe symptoms develop or when the extended family network is geographically distant or is itself overtaxed by problems of poverty, substandard housing, physical or mental illness etc. situations all too common for the Black elderly person today, outside intervention is crucial.

Of course, specialized geriatric mental health services must exist, first of all, and exist in the communities where the Black elderly reside. In New York City, as in the nation, the geriatric population is grossly underserved with respect to mental health. Here in Manhattan, the Manhattan Geriatric Committee and the NYC Department of Mental Health have identified priority service areas based on their high density of elderly, of elderly living alone and their limited mental health services. (They are Community Districts 6, 8, 11, 12, also 4 and 10). Significant numbers of Black and other minority elderly reside in these areas.

Once services exist, they must be affordable. It is imperative that medicare begin to cover the costs of mental health care more adequately. The proposed legislation is an important step in this direction. However, 20 visits annually may not address the needs of the chronically mentally ill elderly who require, for instance, day treatment for an extended period, or who may require other supportive clinical services indefinitely.

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To engage Black elderly in need, various forms of outreach are required. These can take the form of providing community education about services and about geriatric mental health to churches, neighborhood senior centers, medical clinics and social organizations which Black elderly frequent. Outreach can also extend between levels on the continuum of care. The referral process can include direct contact with a representative of the new agency on-site at the referring agency prior to discharge.

The provision of concrete services should not be overlooked in mental health care. As a first step, tackling concrete needs is a way of meeting clients where they're 'at' and helping them to be more available and comfortable to work on other issue

Nursing home residents, the homebound and shelter residents are special subgroups whose mental health needs must be addressed.

Providing a continuum of mental health care requires the provision of services for nursing home residents. In some instances, able residents might benefit from participating in psycho-geriatric programs offered in the community if medicaid disincentives were removed.

In-home treatment should be provided not only as crisis intervention but as on-going treatment for Black elderly whose physical or mental state renders them homebound. There is a sizeable group of elderly, for example, both Black and non-Black who are living alone often in public housing and who exhibit paranoid symptoms and other behaviors which greatly distress them and those around them and who will not seek any type of service including physical health care. However, they often accept treatment if it is brought to them

It was estimated that in New York City in 1976 (Garrett and Bahr, 1976, p. 372) 24% of the homeless women were age 55 and older. Again this group is disproportionately Black. Often they have psychiatric admission histories or present mild organic mental disorder. On-site assessments and supportive services for

the elderly in shelters need to be expanded.

And, what about servicing Black elderly men? Though their numbers are fewer, they too have mental health needs. Widowers in particular may require an array of services and yet have great difficulty accepting these from 'strangers' when family are unable to do for them.

However, true "access" requires more than developing services and getting people enrolled in them. How can we optimize the Black elderly's use of mental health services both quantitatively and qualitatively? We must acknowledge that in addition to all that they share in common with all elderly, the Black elderly have a different - not deviant - but different experience of living and being which impacts their experience of aging. For example, it is commonly held that older Black women adjust more easily to the loss of a husband because they have shared more equally with men the responsibilities of managing a household throughout marriage. (Tate, 1983, p. 98). While this 'adjustment' may be true in concrete terms, clinicians must be aware that her seeming adjustment in some areas may overshadow a heightened sense of powerlessness or loss of control over her life which she cannot recognize or articulate. Her 'I can do it all', I've got it under control posture' is not just an individual style but is a role carved out for Black women which is reinforced by her social context. It is important that the concept of the team approach, so widely accepted in the field today come to include not only interdisciplinary care but culturally relevant care. Black geriatricians in the mental health professions need to be apart of this team to aid the articulation of these important nuances. The existence of Black professionals at all levels of the service unit can also increase the clients sense of trust in the organization and

therefore, their willingness to accept the servcie.

Most importantly, mental health services for the Black elderly need to intervene in their social network, i.e. family, friends, neighbors, ministers, home attendants or whomever the significant others are. Services must be comprehensive, to address the variety of needs the families may present. However, a plan to significantly and positively impact the mental health of Black, elderly people, must simultaneously address their poverty and unequal access to opportunity at all stages of life.

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The CHAIRMAN. In listening to the testimony, I heard many similarities in relation to mental health needs within both the Black and Hispanic communities. I was surprised that the similarities are so basic, and that the problems are much the same. There is a difference when it comes to the language barrier and the effect of that barrier in meeting the mental health needs in both communities.

I would like to direct the first question to Dr. Mahard because she mentioned that low levels of acculturation are significantly associated with greater mental health problems. Does this finding lead one to assume that we should be developing program to acculturate the Hispanic elderly to the mainstream culture? This is perhaps a $64 question and it has other implications. But as an expert in this field, what is your opinion with regard to that?

Dr. MAHARD. My opinion is that this is an extremely complex question. Let me make a few observations.

The term acculturation encompasses very diverse aspects of the relations between cultures. Language, ethnic identity, socioeconomic mobility are some of the factors that are involved in the acculturation process.

These affect mental health in different ways. In addition, which factors are important at a given time depends on both the person's stage in the life cycle and on how much acculturation is needed in order for the person to function effectively.

What is most relevant to the mental health of elderly Puerto Ricans is how acculturation or a lack of it affects their ability to function effectively on those occasions when they must come into contact with the dominant culture. This comes down primarily to an issue of language.

Twenty-two percent of the elderly Puerto Rican population are completely unable to function in English, and I think particularly for this group programs geared towards helping them to gain access to needed services would be beneficial.

There also are life cycle considerations. One of the major reasons that acculturation is desirable from a mental health standpoint is that it governs one's access to higher education, to better jobs, to better incomes. These issues of socioeconomic mobility are more relevant for younger people whose formal education and labor force experience lie ahead of them.

It's also important to point out that the socioeconomic gains that come from greater acculturation may also entail considerable psychological cost. Several studies suggest that as one acculturates to the dominant culture, one may experience identity confusion and value conflicts between the two cultures. A number of researchers have argued that as acculturation increases, ethnic identity is lost and the loss of ethnic identity deprives the person of a very valuable resource for coping with systematic prejudice and discrimination.

This is a very complex issue and one that is in need of greater research. We really don't know what the factors are that allow some people to interact effectively with the dominant culture while retaining the mental health benefits that are embedded in the traditional culture.

The CHAIRMAN. You stated also in your testimony that the matter of acculturation would affect both men and women. But you also stated that women have significantly higher levels of depression than men. Ms. Morrison stated the same thing with regard to Blacks, as did Ms. Sullivan.

Why is that the case?

Dr. MAHARD. As you have observed, this is a general finding that's been observed for a number of years. Numerous studies show that women are more depressed than men.

In terms of the data from our study, we see very clearly that the women are worse off on the various risk factors for mental illness. Some of these risk factors they share with other women from other groups, and some are more culture specific.

Puerto Rican woman have in common with other women in our society the stress that comes from occupying less socially valued role than men, and in addition they face sex discrimination within their own culture.

In general older women are poorer than men and they're also less likely to be married. In the case of Puerto Ricans, these gender differences are particularly pronounced.

The fact that elderly Puerto Rican women are less likely to be married than the men, also means that they're more likely to be living alone Puerto Rican women are also more likely to experience acculturative difficulties than men and also migration related stress, particularly homesickness for family and friends who are still in Puerto Rico.

The CHAIRMAN. Ms. Jones-Morrison, your testimony was very interesting to me, particularly in relation to the statistics that you mentioned. The one thing that became of great interest to me as you were talking was that religion and its associated networks is a critical component. Could you elaborate on that?

Dr. JONES-MORRISON. Let me qualify that by saying that is true for some Black older people. We don't want to overgeneralize. I think certainly if you go to Black churches on Sunday you will find more women there, and it may be related to historical patterns, so I think the church is probably a source of support by my observation more for women than it is for men, and it is not true for all women.

However, certainly for a significant portion of the Black elderly, the church is a major source of social support, it reduces isolation. There is a variety of activities which go on around the church, there is a value of prayer that Dr. Sullivan mentioned. It does help.

I think that in times of stress, many Black churches have clubs or groups of women who visit the sick or depressed, and there is a lot of outreach into the community from church networks.

I happen to have had the occasion to go to Philadelphia with a friend of mine who is very fond of visiting these "speakeasy" beer joints that operate on Saturday nights. When the guys come in from work, they sit around and drink. You walk past the house and you'd never know they were serving alcohol inside. It looks like somebody's house.

One of the things that I did observe was that after several drinks the men—it was predominantly older Black men—began to sing basically religious songs, and they began to testify in a manner simi-

lar to behavior that I observed on Sunday morning in church among the women.

I think it's the issue of how we define religiosity and spirituality and where people get their support. We tend to think of it in the structure of a formal church, but there may be other ways that older Black males are getting this kind of support.

The CHAIRMAN. We find in one instance that the church is somewhat helpful and more women go to my church than men, and I suppose it seems true in most churches. Still, women suffer more depression.

My question is what are we going to do about it? What has to be put in place in order to meet this problem directed at the women of our communities? I'm of the opinion that we're not doing enough, that a lot more has to be done. An opinion from me is meaningless. I'm not an expert in this field.

Ms. SULLIVAN. I think to some extent, women in general are socialized to be a little more comfortable asking for help. At the same time, when that help cannot be provided by informal networks and needs to come from a more formal network, from an organization, Black women might be less likely to use those kinds of services or to even know about them.

As Dr. Morrison mentioned, the stigma associated with 'mental problems' may keep both Black men and women away from treatment.

Still, Black women use services certainly more than Black men. However, outreach is important because when services exist, the burden is on the formal networks, the organizations which we represent to reach out to them and we need in that case to go to where they are.

The CHAIRMAN. What specific things do you suggest the committee recommend to the Congress of the United States? What do you think we should tell the Congressmen to do?

Dr. JONES-MORRISON. There are a lot of things I'd like to tell the Congress to do. One of the issues relates to depression in older women. As our society changes, I think that the roles we ascribe to older women, and therefore the value within those roles, have changed significantly.

We now have the case where many grandmothers are not living anywhere near their grandchildren. Their major value role in society was that of caregiver of their children and grandchildren and we have removed that.

I would like to see a lot more creative programming where we give older women truly meaningful roles. We may have to reconfigure what it is we ask them to do and ascribe a value to that.

One of the things I'm concerned about is this issue of playing off the needs of the elderly versus the needs of children. I think that that kind of intergenerational conflict is particular divisive when you're talking about minority families because the needs are so great on both ends of that spectrum.

While we're talking about problems in finding significant daycare and the problems of after school programs for children, we have a whole group of older women who are out there with nothing to do. If we could think about ways of using them in very real significant ways, reintroducing a system whereby they can begin to

assume more of the caregiving—things that they're so gifted at—we could begin to solve some of the problems with both the older people and children.

I think it's a matter of making their needs a priority and thinking creatively about how we can organize programs that meet the needs of multiple groups at the same time.

Dr. MAHARD. I think the observation that both other witnesses have made, that women may be more likely to admit to these problems, is probably true in the elderly Puerto Rican population as well.

I say probably because the actual utilization of mental health services is so low in the total population that it's not possible to do an analysis of gender differences.

Only 2 percent of the population went to a community mental health center in the last year. This suggests that there is great need for outreach in this population, particularly in terms of the women. Programs that would bring these women into contact with each other and perhaps provide a socialization experience and reduce isolation could have very beneficial effects.

Dr. JONES-MORRISON. I have a concern which relates to the measurement issue that I raised before about suicide, and that is the gender difference in the fact that women are more depressed.

That may be real, but I want to offer one alternative hypothesis that I think takes some serious investigation. If you look at traditional scales which measure depression and you look at the items that are in those scales, they have items such as, do you feel blue? Do you experience crying spells? A lot of those behaviors are the types of behaviors which either may be more characteristic of ways women respond to emotional crises and/or the kinds of behaviors that they are more willing to admit to.

I'm concerned that we are really missing a lot of depression in older men because of the way that we measure it, and I think that the degree of alcoholism that is very common in older men, particularly Black older men, in my opinion is a marker of depression and we're not picking it up accurately. I think that that's one kind of research where I'd like to see a lot more investigation done.

The CHAIRMAN. My esteemed colleague from Queens, Congressman Thomas Manton.

Mr. MANTON. We have another panel, so I'll keep my questions brief. I want to compliment the 3 panelists who have already spoken and submitted very comprehensive testimony with ample citation. It will be very helpful in our committee report.

Dr. Jones-Morrison mentioned although the Black elderly population do not have the sort of language barrier that Hispanics might have, yet they're not really communicating. Would you elaborate that for us?

Dr. JONES-MORRISON. I thought it was important to mention that because very often because people are English speaking, we assume they don't have a communication problem. We know that communication occurs on many levels in a lot of ways other than just the words that we use.

The way people interact with each other on a interpersonal level is part of communication. I become very disturbed when I see health or mental health providers who address older Black people

by their first names without being given permission to do so. I think that that communicates an historical and power relationship which tends to say I am the power provider and you are here for me to take care of you. That's the kind of communication where the message that's being sent is a very interesting message.

If you look at where older Black people are from, many of them who are from the south and have grown up under very strict codes of conduct between Blacks and whites, and patterns of communications between Blacks and whites carry over into old age. They are less likely to complain, they can be afraid of retaliation. They may want to say what they think is going to get them the most service with the least amount of hassle, whether they are clearly articulating what their needs and problems are or not.

I think the training implications of that have a lot to do with helping mental health professionals learn things like proper deportment with older people and that's true for Hispanic elderly as well as Black elderly. What is the first manner of approach, a manner of address which communicates to the older person that I respect you as an individual and as an older person.

I also think that it means communicating in way that begins to develop a level of trust where people would begin to tell you what the real deal is, and it takes time to do that. We are in such a rush usually in delivery of services—we've got 45 minute sessions or we want people in and out in 15 minutes, and it takes a lot of time and patience in working with older people to develop a proper demeanor and manner of communication.

Very often our providers are in too much of a hurry to do that. The result is people don't get served and they don't get properly treated, so I think part of the training of students means that you may have to take it a little more slowly in the beginning, but the gains of doing that in the long run certainly offset the time saving that you may think you have in the process.

Mr. MANTON. Thank you. You talked about historic networks that existed primarily in the rural south where you have extended families and so on. And then you referred to great migration north, many patterns were destroyed by people being away from the extended family and all the other things that happened. How do we go about rebuilding that type of network?

Ms. SULLIVAN. That's a tough question. One has to understand that those networks grew out of a limited access to other services. On the one hand, if we're going to intervene successfully, I think we have to acknowledge that informal networks do exist, recognize their importance, and work with these entire systems rather than focus upon the older Black person only as an individual because they do not necessarily see themselves that way. They may see themselves maybe very related to others.

We, as representatives of formal helping networks should focus on seeing that those networks are more accessible. Informal networks are determining for themselves what their needs are.

Mr. MANTON. Your study made reference to a sample of Puerto Rican elderly. Does that result easily translate for all Hispanic groups, or is it one more specific meaning with Puerto Ricans?

Dr. MAHARD. That is a good question—Puerto Ricans are a specific Hispanic group. They are not the same as Mexican Americans, or Cubans or Dominicans or other Hispanic groups.

In terms of the findings I addressed today, some of these apply to other Hispanic groups and some do not. Higher depression on this particular measure has not been reported in the literature for other Hispanic older groups, but there are very few mental health studies of any older Hispanic groups.

Demographic factors such as education, tend to be similar for Mexican American and Puerto Ricans, except that Puerto Ricans are poorer and less educated, but both groups are rather disadvantaged. Cubans on the other hand tend to be a much more middle class group.

There is really great diversity within the Hispanic population as well as within the Black population, and I think it's important for us to talk more and focus more on that diversity, help us to overcome this tendency to look at older people as a homogeneous group. Older people are not all the same, whether they're Hispanic or Black or members of another group.

Mr. MANTON. Thank you very much. There's so many questions that come to mind, we could probably stay on this matter the entire day, but we'll turn it back over to our Chairman.

The CHAIRMAN. The Chair will now recognize the next panel. Janet Sainer, Commissioner from the New York City Department of Aging; John Kastan, Assistant Commissioner for Planning and Project Management; and George Casimer, from the Kingsboro Psychiatric Center here in the City of New York.

Commissioner Sainer, you may proceed.

STATEMENT OF JANET S. SAINER, COMMISSIONER OF THE NEW YORK CITY DEPARTMENT FOR THE AGING

Ms. SAINER. Good morning. I am Janet Sainer, Commissioner of the New York City Department of the Aging. I am very pleased to be here today for this very important hearing on the mental health needs of minority older persons.

We appreciate your having this hearing in our city, and that it has been possible for some of our Congressmen—Congressman Garcia and Congressman Manton—to be here today. I am very appreciative of their presence as well as of yours, Congressman Roybal.

It is heartening to know that you all share our concern with the mental health needs of older people since they have not received the attention that they deserve in this area. Over the past 2 decades, as the awareness of the dramatic rise in the number of older people has heightened, we have seen the burgeoning of a wide variety of community based services and programs directed to the needs of older people.

Regrettably, however, the support for mental health services has not kept pace with that for other services.

Although it is heartening to know that most older Americans are well functioning individuals with little or no evidence of mental disorders, change is going on within the elderly population that

quite clearly increases the potential for mental health problems to occur.

Here in New York City we see, first, a rapidly growing functionally impaired group of elderly 75 and over as well as 85 and over.

Secondly, increasing numbers of elderly living alone. Most usually, older widowed women.

Third, increasing numbers of minority elderly. I thought you'd be interested in knowing that approximately one of every four elderly in New York City is a minority group member.

Each of these groups is subject not only to the stresses of aging but, as our former panel so eloquently enunciated, also to poverty, inadequate housing and poor health, which researchers show to be highly associated with mental health problems.

As a group, minority elderly experience these stresses to a greater and more serious degree than do other elderly.

While I am going to try to highlight only a few of these because their relation to mental health was well stated before. I do want to say that while poverty is found among all groups of elderly, it is significantly more prevalent among Blacks and Hispanics. A recent study of our department has found that nearly half of all Black and Hispanic elderly households and a third of Asian households have incomes under $5,000 compared with 28 percent of white households.

We also found that half of the Hispanic women living alone and 42 percent of the Black women living alone were in poverty, as compared to the overall rate of 13.6 percent for the older population as a whole. These figures relate to New York City specifically.

Moreover our concern is heightened by the fact that the rate of living alone, which we think has a great deal of relevance to mental health needs, has risen from 22 percent in 1970 to 26 percent in 1980 for Hispanic elderly.

In addition, substantial proportions of minority elderly live in neighborhoods in the city with high crime rates, and in some of the oldest housing. The impact of these burdens and stresses makes the minority elderly especially vulnerable to mental illness.

Over 10 years ago, our department documented the fact that Hispanic elderly were the most vulnerable compared with Black and white elderly.

Added to the economic deprivation that they experience is also—and this highlights the question that you raised, Chairman Roybal—the strain of acculturation and the conflict between the traditional and the newer ways of life that younger generations are accepting. Subsequent research has obviously supported those findings.

Hence, our department has made particular efforts to target services to the minority elderly, especially those who face barriers of cultural and language differences.

I think you know that our Department for the Aging is the Area Agency on Aging for the City of New York and therefore is the recipient of Older American Act funds, in addition to State funds and other city funds.

As a result of special efforts to target our services, we established years ago the first minority affairs unit in any area agency in the country. We also obtained a few years back, a Federal grant to

enable us to test new ways to reach and serve the minority elderly, which relates to part of the questions that you raised with the earlier panel.

Much of this initiative was directed to those Hispanic elderly who are living not in the dominant Hispanic communities but are living in smaller clusters in non dominant communities throughout the city, where the inability to speak English is truly a barrier. We have looked at ways to address the problems of this population so that those who have the opportunity to move into nondominant Hispanic communities may also have the opportunity to be a part of the community in which they live and use more effectively the available resources that they traditionally might not take advantage of because of language barriers and cultural values.

Moreover, our department in allocating new funding when we get it, so that it is targeted to the economic and socially needy elderly as indicated in the Older Americans Act. We do it by using a formula which we call the one-six-one-one formula. We count every person as one, we count every minority person as another one, we count poverty as an additional factor of 6, and we also, in looking at the frail elderly, add another factor of one for those over 75. Therefore when we distribute the monies that do come to us, we try to look at it in connection with these factors which we believe have an impact on the minority, elderly and poor elderly in our city.

These efforts have been very effective. The proportion of the minority elderly served by our programs exceed their proportions in the total elderly population in our city.

In 1987, 32 percent of the elderly served through our programs were members of minority groups compared with 24 percent in the overall population.

In 1986, 25 percent of all our local community sponsors were minority sponsors. We make a very special effort in that direction.

A recent mayoral initiative provided tax levy funding to create an Hispanic Enhancement Program specifically targeted to Hispanics to expand and improve services to them. As part of this effort, we established a citywide Bilingual Helpline with a special phone number and bilingual staff who in 1987 responded to over 10,000 walk-in and telephone inquiries for assistance.

In addition, in response to some of the questions you posed earlier, we also established English-as-a-second-language classes, using the community colleges and their faculty. We had programs last year in 12 different communities, which were very highly attended. There is now a waiting list, and we're renewing it again.

We have tried to do translations of all our benefits and entitlement forms and our literature which can be given out to the elderly. We've established a 100 page guide called a "Guia de Recursos Para Personas Mayores De La Ciudad de Nueva York." It lists the various services available in New York, in Spanish, so that people can understand it and use it.

We've also had special training programs for those low income elderly who are in our employment programs, and have had two of them in Spanish. These are a few of the special things we've done in order to help overcome some of these barriers.

However, even the best strategies for outreach programming and allocating resources do little if the services do not exist. The need is truly there, but it is paradoxical that as the elderly population has been growing, bringing with it increases in the number of vulnerable elderly, public policies for the past 20 years have limited access to mental health services.

Moreover, because older persons tend to be more isolated, their need for help is often not recognized until their condition has seriously deteriorated. This is especially true of those who live alone. It's only when rent or utilities go unpaid or behavior becomes bizarre that help is sought by family members and friends.

Very often, it is an aging services program funded by the Older Americans Act that first sees the older person needing help, and this is very important to remember because the ability of those people in senior centers and home care programs to be able to know and see and recognize the early symptoms of mental illness and then be able to do something about them is very critical.

In our home care programs, as is true for the Medicaid Home Attendant Program in our city, we're encountering increasing numbers of mentally frail elderly among the home bound. They're a hard to serve population and doubly hard unless mental health services can be made available as an adjunct to our home care.

Therefore, as we look at public policies related to mental health services, recognizing the growing numbers of in home elderly, we must take into account the importance of bringing to the home some of the services that are needed. I must say that we work closely with our Department of Mental Health in our city in developing some of these in-home services and I know that my colleague on the panel, Mr. Kastan will be describing them so I will not.

It's not only the homebound that need mental health services. Our almost 300 five-day-a-week city senior centers have experienced the aging in of their membership. Many of the members who were well elderly 10 or 20 years ago are now frail, needing much more supportive help, and they present needs and problems that center staff are both unequipped to handle and frequently do not have the time to handle.

This combination of an increasingly large frail population and a familiar setting I believe makes senior centers an excellent base for the outreach that you spoke of, for case finding and even the provision of mental health with qualified professionals from the mental health system. At present, there is only very limited support to deliver these services that are so vitally needed.

We here in New York City have taken some significant steps to provide these services and most of these have been collaborative efforts involving other city agencies, particularly the New York City Department of Mental Health, Retardation and Alcoholism Services. I'm sure Mr. Kastan will make mention of the directory which both our departments put out 2 years ago, the "Directory of Mental Health Services for Older Adults in New York City," which is available and I think is impressive in terms of what services mentally ill elderly could use. But insuring that the minority elderly utilize these services is very important.

Instead of citing the scope of these programs, I would like to cite two examples because I think they are a partial answer to your in-

quiry of what could be done from a legislative point of view and from the kind of initiatives that Congressman Roybal proposed.

I would like to cite the successful example which meshes Older American Act funds, the congregate food program funds, the home-delivered meal funds and mental health funding from the city and State departments of mental health.

This program I'm referring to is right here in your borough, Congressman Manton. It's the Friendship Center in Jamaica, Queens, which offers a gamut of support services within the framework of a congregate meals program.

It is noteworthy that the Friendship Center is designed exclusively for the frail elderly, it is not for the well elderly. Fifty percent of its membership has been deinstitutionalized—they have lived in institutions and they are a very mentally frail population. But we do provide a setting, and interestingly enough, we do not call it a mental health facility. We call it the Friendship Center.

I believe the outreach position that we've taken to be very important to the center's success. In addition, to our department's funds and city Department of Mental Health funds, we've involved the State mental hospitals, Creedmore State Hospital has been very actively engaged in this. And we have linkages with the local community and mental health clinics who bring their staff to the center, not waiting for the elderly to come to their facility. I think these efforts are important to recognize as we look at how we can fashion the kinds of programs which the mentally frail elderly will use.

I cite this because I believe it's a model of service delivery which merits consideration and replication and we have a good deal of material on this that we'd be happy to share with you in the future.

Another collaborative effort, and this relates to your borough Congressman Garcia, was a recent effort of a number of our city agencies, HRA, the Department of Mental Health and our department to develop an in-home geriatric mental health treatment program, and this, unlike the other program, was directed to those who are homebound. This service reaches out in a multi ethnic area of the Bronx, bringing both diagnostic and long-term mental health services to mentally disabled people in their own homes.

The project is a little over a year in its operation and we'll have much more data as we go along.

We are pleased there's been a steady growth of services for older mentally ill persons and that minority elderly are sharing these services. However, let me emphasize that most of these programs are small, many of them are just demonstration projects and do not begin to meet the total need. We have the structure but not the financial support to expand its capacity and, if we are to develop more community based mental health treatment services and also train mental health professionals as was indicated earlier, then we must have increased funding.

We therefore strongly support your efforts, Congressman Roybal. to launch the elderly and mental health initiative. Indeed, I must point out that the City of New York in its Federal legislative program for 1988 supports initiatives to expand mental health coverage to low income and elderly individuals through Medicare and Medicaid.

In my comments today, I am reflecting not only our own department's concerns but also that of the Mayor as well. We are particularly pleased by the changes you've proposed in Medicare and Medicaid coverage for mental health services. Medicare's current mental health benefits for both inpatient and outpatient care I believe are so restrictive that it is difficult to view them as truly benefits.

Moreover, we are also pleased that your proposal would permit a wide array of trained mental health professionals to provide services and to enable those organizations and individuals to be reimbursed under Medicare.

We further endorse your incorporating medical management of mental health as a position service. We are in agreement with this not only because it would mean mental health care would not be subject to visit limitations which in the area of long-term care are not very helpful, but also because an older person's mental health is so intertwined with their physical well being or poor health.

If the goal of mental and physical well being for the older person is to be achieved, we believe that a high level of coordination must exist between their mental health and physical health.

There is one point that I want to make regarding expansion of benefits. I am not sure whether your legislative initiative—I hope we can talk with your staff and other about this—would cover those elderly afflicted by what we've labelled mental deterioration rather than mental illness. Mental deterioration is the result of such conditions as Alzheimer's or arterial sclerotic actions.

Although strictly speaking, these elderly I believe are not considered to be suffering from a mental illness that is responsive to treatment, they are mentally impaired and certainly need services. A means of reimbursement for these services just as for other mental health services, is critically needed.

I would ask you in your deliberations and in your Congressional activities not to let this group of the mentally frail elderly fall between the cracks of either programming or reimbursement mechanisms.

Another point I would like to make is that because older people have not always readily accepted mental health services, it is my firm belief as a result of the experience we've had in developing programs that we must bring services to where the older people are, and not expect them to recognize their problems, accept their problems and then walk into a community mental health center or a mental health facility.

I believe that bringing services to where older people are, to their centers, to their homes, to their churches if need be, to the places where older people gather and can be seen is a very important component that we must take into account. Our own experiences have shown that where a facility or even a part of a facility can be set aside for the frail elderly without being labelled as a mental health facility and where a supportive but not highly structured environment is provided, older people will come and effective services can be rendered if we have the kind of professional staff who can know and understand and deal with these problems.

I hope that your initiative will permit services to be delivered by mental health professionals cutside a traditional mental health settings and still be reimbursable.

In conclusion, we applaud your proposals for expanded research, education and training in mental health, and this 3 pronged approach can go far to change current attitudes on the part of mental health professionals as well as on the part of the elderly themselves.

In closing, let me commend your initiative because I believe you have identified and put into writing the many important components that must be addressed, especially liberalizing Medicare and Medicaid coverage, which would go far to remove major barriers to the delivery of critically needed mental health services to the elderly. We are happy to support your efforts to achieve this goal and look forward to the day when all who need these services will be able to have them.

Thank you very much.

[The prepared statement of Ms. Sainer follows:]

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TESTIMONY

Presented by

Janet S. Sainer, Commissioner
New York City Department for the Aging

on

MENTAL HEALTH NEEDS OF MINORITY OLDER PERSONS

at a

Hearing Held by
Hon. Edward R. Roybal, Chairman
Select Committee on Aging
The U.S. House of Representatives

at

Queensbridge Houses Community Center
Long Island City, New York

May 13, 1988

I am pleased to be here today at this important hearing on mental health services for the elderly. As Commissioner of the New York City Department for the Aging, which is both a department of City government and the largest Area Agency on Aging, representing 1.3 million older New Yorkers, I share your concern that up to now the mental health needs of older people have not received the attention they deserve.

Over the past two decades, as awareness of the dramatic rise in the number of older people in our nation has been heightened, we have seen the burgeoning of a wide variety of community-based services and programs directed to their needs. Regrettably, however, the support for mental health services has not kept pace with that for other services.

Although it is heartening to know that most older Americans are well-functioning individuals with little or no evidence of mental disorder, it is equally important to recognize that older people, and in particular those over 75, are subject to a much higher risk of developing a disabling mental illness than is true for any other age group. Large numbers of elderly experience multiple life stresses -- the loss of a spouse, of family members and friends; the onset of chronic, disabling illness, which often leads to depression and other emotional problems and, with advancing age, the prevalence and magnitude of the problems multiply. In addition, the mental frailty that results from certain physical conditions, which bring memory

loss and disorientation, is another unfortunate reality of later life for more and more elderly.

Changes going on within the elderly population point clearly to an increasing potential for such problems to occur. Here in New York City, we see:

-- a rapidly growing, functionally impaired group of elderly 75 and over, as well as 85 and over, who will need a variety of health and social supports to sustain them and whose economic status was largely determined nearly a generation earlier.

-- increasing numbers of elderly living alone, most usually older widowed women whose economic status deteriorated significantly with the death of their husbands.

-- increasing numbers of minority elderly who often bring to their older years a history of poor health and a lifetime of low income. Today approximately one out of every four elderly New Yorkers is a minority group member.

Each of these groups is subject not only to the stresses of aging but also to those of poverty, poor or inadequate housing, and poor health which research has shown to be highly associated with mental health problems. As a group, the minority elderly experience these stresses to a greater and more serious degree than is true for other elderly.

For example, while poverty is found among all groups of elderly, it is significantly more prevalent among Black and Hispanic elderly. A recent study of the income status of the City's elderly made by our Department found that minority elderly-headed households were disproportionately represented in the lowest income levels. Nearly half of all Black and Hispanic elderly households and a third of the Asian had incomes of under $5000 compared with 28 percent of the white households.

And while poverty among the elderly was highly related to living alone, being female and very old, being an older female minority group member is almost a guarantee of poverty. Half of the Hispanic women living alone and 42 percent of the Black women were in poverty as compared with an overall poverty rate of 13.6 percent for the older population as a whole. And I scarcely need remind you that low incomes and poor health go hand in hand.

Moreover, our concern is heightened by the fact that our analyses show an increasing proportion of Hispanic elderly living alone as cultural patterns change. The rate of living alone had risen from 22 percent in 1970 to 26 percent in 1980 for Hispanic elderly.

In addition, substantial proportions of minority elderly live in neighborhoods of the city with high crime rates and some of the oldest, and therefore substandard, housing stock. Although Hispanic elderly are still found in significant numbers in traditional neighborhoods, they are

also living in smaller numbers in neighborhoods where they are a minority in a non-minority community and, thus, are often invisible.

The impact of these burdens and stresses makes the minority elderly especially vulnerable to mental illness. Indeed, over 10 years ago, our Department as part of a major cross-cultural study of inner city elderly in New York, documented the fact that Hispanic elderly were the most vulnerable compared with Black and white elderly. For, added to the economic deprivation they experience is also the strain of acculturation and the conflict between the traditional and newer ways of life that younger generations are accepting. Subsequent research has supported our findings.

Largely as a result of our early research, our Department has made particular efforts to target services to the minority elderly, especially those who face barriers of cultural and language differences.

As you may know, we established the first Minority Affairs Unit in an Area Agency. We also sought and obtained a federal grant to enable us to test, through a demonstration project, new ways to reach and serve the minority elderly. Much of this initiative was directed to those Hispanic elderly who, as I mentioned, are living in small clusters in non-minority communities throughout the City where the inability to speak English is truly a barrier.

We have also emphasized the use of special outreach and programming to provide services in culturally familiar and acceptable ways. Moreover, in allocating new funding to the communities, we use a weighted formula which takes both numbers of minority group elderly and numbers of those at or below poverty into account in determining the relative needs of communities for new support. Thus, resources are directed to areas where these subgroups of elderly are concentrated.

Our efforts have been effective. The proportions of elderly minority group members who are served by our programs exceed the proportions of these men and women in the total elderly population. In 1987, 32 percent of the elderly served were members of a minority group compared with 24 percent in the overall population.

Moreover, we have identified minority sponsors to carry out our programs. In 1986, 25 percent of all sponsors of Department-funded programs were minority sponsors.

We have also created an Hispanic Enhancement Program, a unit devoted exclusively to the needs of Hispanic elderly to help us improve and expand services to these elderly. As part of this effort, we also established a citywide bi-lingual help-line which responded to 10,000 inquiries for assistance in 1987.

However, even the best strategies for outreach, programming and the allocation of resources do little if the services do not exist or are of limited capacity. And that, unfortunately, is the case in regard to mental health services.

It is only recently that attention has begun to be given to the needs of the mentally impaired elderly. There are numerous reasons for the fact that the elderly have up to now constituted only a tiny fraction of those who receive mental health services. A major reason, of course, as your initiative recognizes, is reimbursement policy which severely limits support for use of these services by older people. Then, too, there is the attitude of older people themselves who have tended to see a social stigma attaching to the acknowledgment of mental health problems and are reluctant to seek professional help for them, especially if this required going to unfamiliar facilities. There are, also, the conscious and unconscious attitudes of mental health professionals toward the elderly.

Yet the need is there. It is paradoxical that as the elderly population has been growing, bringing with it increases in the number of vulnerable elderly, public policies have for the past 20 years limited access to mental health services. Under deinstitutionalization, rigid eligibility criteria barred most persons from admission to institutions but the needed community-based services were slow to develop and in short supply.

There is another aspect to mental health needs of older people that should be borne in mind. Younger people who suffer from mental problems tend to get assistance more quickly than do the elderly because these problems impact on jobs and families. Because older persons tend to be more isolated, their need for help is often not recognized until their condition has seriously deteriorated. This is especially true of those who live alone. Then it is only when rent or utilities go unpaid or behavior becomes bizarre that help is sought by concerned family and friends.

The aging services network is an important source of case-finding and referral.

Very often, it is an aging services program that first sees the older person seeking help. Our Department funds 35 case management agencies which provide access to the Department's home care services for the homebound elderly as well as a wide range of benefits and entitlements from other systems. A key responsibility of these agencies is their assessment of the total needs of the person. If there is an indication of need for any special type of assessment such as a psychiatric evaluation, program staff must ensure these are made so appropriate services can be arranged.

And I must tell you that these programs, as is true for the Human Resources Administration's Medicaid-supported Home

Attendant Program, are encountering increased numbers of mentally frail elderly among the home bound -- a very hard-to-serve population unless mental health services can be available as an adjunct to our home care.

But it is not only the homebound who need mental health services. Over the past decade our City's senior centers have experienced a new phenomenon -- the "aging in" of their membership (who may have been the well elderly, some 10 to 20 years ago but who now have reached an older, frailer period in their life). They frequently present needs and problems that center staff are both unequipped and do not have time to handle. This combination of an increasingly large frail population and a familiar setting makes senior centers an excellent base for outreach, case finding, referral and even treatment. But at present there is only limited support to deliver the mental health services that are needed.

In the face of the challenges we have encountered over the past two decades, we here in New York City have, I believe, taken some significant steps to address the look of mental health services for older people. And, I might add, most of these have been collaborative efforts involving other city agencies and the City Department of Mental Health, Retardation and Alcoholism Services in particular.

As a result, within the past few years, there has been an encouraging expansion of community-based mental health services for the elderly of New York. Let me emphasize,

however, that most of these programs are very, very small in size and do not begin to meet the need. We have the structure but not the support to expand its capacity or replicate the models that have proved effective in delivering services.

One example of a successful model for which there is no reimbursement mechanism to replicate is that which has been developed at the Friendship Center in Jamaica, Queens between the Jamaica Service Program for Older Adults and Creedmoor State Hospital's Senior Center for LIving Program. The Center offers a gamut of support services within the context of a congregate meals program. Besides its successful involvement with the State mental hospital, the Center has worked closely with an area hospital to provide on site medical screening, and has developed linkages with the local community mental health clinic for consultation and referral. A select group of hospital in-patients and residents of adult homes are brought twice weekly to the Friendship Center, a city-funded senior center specifically and exclusively targeted to the frail elderly, so that they have an opportunity to interact with other older people living in the community. In return, community-based elderly attending the Friendship Center program have access on site to outstationed mental health staff from the state Hospital (a psychiatrist, psychiatric nurse and community aide) one day a week.

The Jamaica Friendship Center is in itself a model of service delivery which merits consideration and replication. Designed exclusively for the frail elderly -- (50% of its membership have been institutionalized), the program provides the warm low key atmosphere that studies have shown to be most conducive to the maintenance of this population.

A more recent effort involving the City Department of Mental Health, the Health and Hospital Corporation, and our Department resulted in the establishment of two new mobile geriatric mental health services, one in Harlem and one in Coney Island, both communities with large minority populations. These programs are hospital-based but deliver their diagnostic and treatment services in homes and centers and also link clients with specialized hospital services.

Another recently coordinated effort was the creation of an "in-home geriatric mental health treatment team" in the Bronx. This team was the result of joint planning by the Human Resources Administration, the Department of Mental Health, and the Department for the Aging. This service reaches out to a wide multi-ethnic area of the Bronx, bringing both diagnostic and long-term mental health services to mentally disabled persons in their homes. The program is linked to both HRA's and our Department's home care programs.

Yet another initiative of the Department for the Aging and the Department of Mental Health was to jointly produce a

"Directory of Mental Health Services for Older Adults in New York City", which is widely used by social service and health professionals.

Most recently of all, we have expanded the curriculum of our STAY WELL program, a health promotion initiative which is carried out in senior centers throughout the City, to include a mental health component in the curriculum.

So we are pleased that there has been a steady growth of services for the older mentally ill person and that minority elderly are sharing in these services. However, as I noted, these tend to serve small numbers of elderly because their funding is limited. If we are to continue the development of more community-based mental health treatment services and train mental health professionals to understand and work with older clients, increased funding is essential.

We, therefore, strongly support your efforts, Congressman Roybal, to launch the Elderly Mental Health Initiative.

Indeed, I must point out that the City of New York in its federal legislative program for 1988 supports initiatives to expand mental health coverage to low income and elderly individuals through Medicare and Medicaid. So in my comments today, I am reflecting not only our Department's concerns but those of the Mayor as well.

We are particularly pleased to see that your initiative proposes changes in Medicare and Medicaid coverage for mental health services. Medicare's current mental health

benefits for both in- and out-patient care are so restrictive that it is difficult to view them as benefits. Moreover, we are also pleased that your proposal would permit a wide array of trained mental health professionals to provide services and be reimbursed under Medicare. We further endorse your incorporating medical management of mental health as a physician service. We are in agreement with this not only because it would not be subject to a visit limitation but because an older person's mental health is often intertwined with his or her physical health. If the goal of mental and physical well-being for older persons is to be achieved, we believe that a high level of coordination should exist between the mental health and physical health practitioners.

There is one point, however, that I want to make regarding expansion of benefits. We are not sure whether your legislative initiative would cover those elderly afflicted with mental deterioration as a result of such conditions as Alzheimer's and atherosclerosis. Although, strictly speaking, these elderly are not considered to be suffering from a mental illness responsive to treatment they are mentally impaired and certainly need services. Moreover, a means of reimbursement for these services just as for other mental health services is critically needed. As the numbers of the very old increase, the numbers of the mentally frail among them are also growing. The experience of our City programs testifies to this daily. In working

toward the implementation of your initiative, I would ask you not to let this group of mentally frail elderly fall between the cracks of reimbursement mechanisms.

Moreover, we would like to urge stronger linkages between mental health services and aging services. Not only are our programs an important source of case-finding, but, our network of community-based case management agencies provides the case coordination important for all elderly persons receiving home care and even more crucial for the mentally frail older person.

We therefore, need to continue to build collaborative relationships between our services and other systems. Mental health services must be an integral part of these relationships.

Another point I would make is that because older people have not always readily accepted mental health services, we need to bring services to them -- to senior centers or to the home. Indeed, the program models I have described are all built on this principle. Therefore, I hope that your initiative will permit services to be delivered outside the institutional setting by mental health professional and be reimbursable. Just as Visiting Nurses are reimbursed for their home services. Our own experience has clearly shown that where a facility, or even part of a facility can be set aside for the mentally frail elderly without being labelled

as such and where a supportive but not highly structured environment is provided, older people will come and effective services can be rendered.

We also applaud your proposals for expanded research, education and training in mental health. This three-pronged approach can go far to change current attitudes on the part of both mental health professionals toward the delivery of their services to the elderly and of the elderly themselves regarding the acceptance of services. Moreover, we would hope that, under either a National Mental Health Education Program or through some aspect of mental health training programs, those who work in aging service supported by the Older Americans Act could also receive some training to enable them to understand symptoms of mental illness and know how to cope with behavior disorders as well as have adequate mental health services available for them to refer to. For, as I noted, in many instances it is aging services professionals who are the first to encounter the problem.

In closing, Congressman Roybal, let me again commend your initiative. We believe you have identified the many important components that must be addressed, especially liberalizing Medicare and Medicaid coverage, which would go far to remove major barriers to the delivery of critically needed mental health services to the elderly. We are happy to support your efforts to achieve this goal and look forward to the day when all who need these services will be able to have them.

The CHAIRMAN Thank you. We are going to deviate from our usual procedure and ask questions of you and we'll yield for that purpose to my friend and colleague Congressman Garcia, who has shown his interest in this subject matter by being present at this hearing and has constantly shown great interest in the problems of the aged, the poor, votes constantly in favor of health and education issues and is one of the outstanding Members of the House of Representatives.

May I yield now to Congressman Garcia.

Mr. GARCIA. Thank you. I came in late, I was attending a meeting in the daycare center, so I've gone from babies to senior citizens. One of the privileges you have as a Member of Congress is that you take a gentleman like Congressman Roybal who represents the city of Los Angeles in California and yet he's sitting here today in Long Island City, holding a hearing, when there are a half a dozen other places he could be today. On behalf of those of us in New York City, I'd like to thank him.

I'd like to especially thank my colleague Tom Manton. Over the years he has been a Member of Congress—we're generally very complimentary to each other, you'll never hear us say a bad word about each other—but I think the proof is really in the pie, and the pie is what happens when a person has to take the fall or has to go on issue. There has never been a doubt in anybody's mind that in every one of those instances Congressman Manton has always been in support of the poor, support of the downtrodden.

I'd just like to say to Congressman Manton that is from all of us, and I speak of those Members of Congress who have deeply appreciated his sensitivity over all these years that he's been with us.

Ms. Sainer, you talked about bilingual education. That has always been somewhat—people running to the President of the United States, as Hispanics, that's the first thing on their agenda—where's the bilingual eduction. That seems to be their agenda.

You mentioned something about that—I speak of my parents when they were alive, their primary language was Spanish. I get a sense that not enough is being done and there's a certain cultural insensitivity I find sometimes as it relates to these people. I know you're trying, but the fact we have a problem and it's not nearly enough, and I ask you what projects do you have and coupled with that, to go beyond that?

Ms. SAINER. There's no question that we do not have enough and there's no question that it's something that we have put on our agenda for city tax levy and, for State incremental funds. I would also hope that it would not be just for the kinds of initiatives that you have been citing Congressman Roybal, but for other kinds of service initiatives which are critical.

My feeling is that, one of the ways that we have succeeded in doing some of the things that we've done, though they are certainly not enough, is through the meshing of resources from other sources. We've talked about this—I mentioned it very briefly in relation to the mental health. In the area of education, we have offered what is labelled English-as-a-second-language classes because we were trying to enable people to feel a little more comfortable—and we're talking particularly in the areas where they're not dominant groups—in going to a senior center where they could be wel-

come, but if they cannot speak, they feel isolated and lost and uncomfortable.

This offering of English as a second language which was a special initiative last year we want to double, triple and bring it to wherever it's needed, where people wish it.

I think there's no question that we want to be able to expand the services at the very local level and give more funds to local groups who are dealing with the Hispanic elderly, which was what you asked about in your question.

I think there are things that we are doing. We have run health promotion programs in senior centers, in 40 of them in the city. We help seniors do all kinds of exercise and stress reduction and all sorts of things and we use health professionals in curriculum courses.

We have offered that in the Washington Heights area to a group of Hispanics in their language. It's small, but I think we have to have the ability, though without funding, or various fundings, we won't be able to do much more.

Mr. GARCIA. 1989 will be a new year. Whatever happens, there will be a new man, a new person, in the White House come January 1989. I don't think it can be as bad as the last 8 years have been for the poor. Is the city of New York prepared to go forth in 1989 with the type of programs that we're going to need to pick up the vacuum that's been created over these last 8 years?

Ms. SAINER. Yes. In some of the demonstrations which I think will be cited by my colleague from the mental health department related to the mental health needs—I think there are a number of those which could be done, even within the Older Americans Act.

We have a series of initiatives proposed for city tax levy funding, so that if you're ready, we're ready. And I'd be happy even in advance over the course of the next months to share with you some of the initiatives we have in mind.

Mr. GARCIA. I'd like to thank you for being here, and I'm particularly delighted I can be here long enough to hear your testimony and have an opportunity to question you.

I'd like to thank my colleague Congressman Roybal and Tom for inviting me here today.

The CHAIRMAN. Thank you. The Chair now recognized Congressman Manton.

Mr. MANTON. I think your approach of trying to do outreach particularly at the senior center level where we have a lot of interaction on a daily basis with many thousand of seniors is a good idea. However, the earlier panel talked about some cultural problems and communication problems and I don't know if this is the appropriate question for you or perhaps I should hold it for the other panelists, but let me throw it out. Is there any effort being made to recruit minority health professionals who perhaps could culturally associate on a quicker basis with our minority elderly population?

Ms. SAINER. I can try to speak to that from the point of the aging services because obviously the need for bilingual people and those who know the culture, even if the language is English, is very critical. The Black community was highlighted today, the minority communities, the Asian communities, the Korean communities—we see this and you see it in Queens extensively—all need people

who know the language and know the culture and who have the professional training.

The director of our Minority Affairs Unit, Valerie Levy, who is well known nationally as well as here is assigned to work with our personnel department as an EEO officer and helps our personnel department insure that we give as many opportunities and do as much outreach to hire minorities for our department, and also for the local programs as possible.

It's unfortunate that we do not have in our city, and it might be something we might want to try and we would if we could, a clearing house, whereby we could know the people who are looking for jobs and we also could feed in those agencies that are seeking people because they need to fill vacancies. We don't have a centralized applicant bank—certainly in the aging field, I think this would be a marvelous effort that I'd like to put in immediately. I get many resumes across my desk from everybody, but I only know through happenstance what's out there. There are more openings this year than we've ever had before and we're looking for qualified personnel of the minority backgrounds and minority cultures that our population represents.

Mr. MANTON. Thank you. I'll turn the mike back over to our Chairman.

The CHAIRMAN. I'm not going to ask a question, but I'm going to ask a favor. I'd appreciate it if you would write me a letter telling me what initiatives the Federal Government can do to help your office become effective in meeting not only the needs of the Hispanic and Black elderly but particularly home care services and friendship centers.

Ms. SAINER. It would be my pleasure. I've been Commissioner for the Department of the Aging for the past 10 years. Before that, I worked for 14 years with the Community Service Society of New York and I was Director of Programs for the Aging there.

As part of my job at the Community Service Society, I helped establish the first Friendship Center in Jamaica, and the Jamaica program, which was initially started as an integral part of Community Service Society's programs and then spun off as an independent agency and now runs a whole series of programs. I take particular pleasure with providing you with some of the information about the Friendship Center type programs that we think can have real impact.

You'll forgive me for leaving, because I would have loved to have heard my counterparts here, but I do have a 1 o'clock meeting in Brooklyn.

[Additional material submitted for the record by Ms. Sainer entitled, "1985 Directory of Mental Health Services for Older Adults in New York City," has been retained in Committee files, and may be viewed upon request.]

The CHAIRMAN. The Chair now recognizes Mr. John Kastan, the Assistant Commissioner of Planning and Project Management for the city of New York.

You may proceed.

STATEMENT OF JOHN KASTAN, ASSISTANT COMMISSIONER FOR PLANNING AND PROJECT MANAGEMENT, ON BEHALF OF SARA L. KELLERMANN, M.D., COMMISSIONER, NEW YORK CITY DEPARTMENT OF MENTAL HEALTH AND RETARDATION

Mr. KASTAN. Thank you. I am John Kastan, Assistant Commissioner for Planning and Project Management representing Sara Kellermann, Commissioner of the New York City Department of Mental Health and Retardation.

I will be joined in the question period by Ms. Marla Degotta who is a staff person with the department of mental health with special responsibilities for planning for the elderly.

The testimony has been submitted for your review and I will briefly identify some of the highlights of it.

The CHAIRMAN. The testimony will appear in its entirety the way it was written and we'd like to ask that you summarize.

Mr. KASTAN. The department is honored to have the opportunity to address the House or Representatives Select Committee of Aging, and the department is especially pleased by the committee's awareness of the acute need for mental health service for the elderly as evidenced by the introduction of the elderly mental health services development back in 1988.

The department's finding and experience in delivering services to the elderly are echoed in the committee's report. The department concurs with the proposed two step strategy, in a short term mental health services in general must be greatly expanded from the elderly. Over the long term, research must be conducted in order to identify the best methods of providing services to the elderly.

The department would like to commend the committee for advocating enactment of a health care consumer bill of rights and including in it the right of all citizens to receive quality treatment regardless of race, religion, gender or creed. The city has supported initiatives that would assure equal access to services for every citizen in its legislative agenda.

In New York City, there are 73 specialized geriatric mental health programs serving the elderly. These include 32 outpatient clinics, 20 mobile units, 15 gate treatment programs, 7 inpatient units and an on site rehabilitation program for elderly residents in the Mark Well Hotel, who is an SRO in Manhattan.

Of this total array of services 40 programs are funded by the department, including 30 in voluntary not for profit sector and 10 in the New York City health and hospital corporation, the municipal hospitals in New York City.

These programs invite services to approximately 15,000 elderly persons annually.

It should be noted that the elderly are served by all adult mental health service providers, municipal, voluntary nonprofit and private in New York City, so that the actual services are available to the elderly, far exceed the specialized geriatric programs that I itemized.

Over the past 10 years, the mental health needs of the elderly are growing. Research in this field estimates that 25 percent of all

the people present significant symptoms of mental illness and 10 percent of that group are actually diagnosed as mentally ill.

In addition, the department through its own planning and needs assessment efforts has documented the growing need for services. In response, the department watched major efforts to the standard of health services in 1985 allocating more than $1.4 million in specialized geriatric programs.

In September 1985, the department for the aging published a directory of mental health services for older adults in New York City. We can make that available to you and I think there are copies in the back of the hall as well. The purpose of the directory is to serve as a resource and referral source for human services providers who serve the elderly.

In fiscal year 1986-87, the department provided for the expansion of 5 clinic programs to serve the elderly, 2 in Queens, 1 in Brooklyn and 2 in the Bronx. In fiscal year 1987-88, the Jewish Association for services from the aged expanded its mobile services in the Bronx to include a Alzheimer's component and 2 clinic geriatric proponents were expanded in Queens and Brooklyn.

The department also implemented the geriatric day program for the developmentally disabled elderly population in Staten Island, the first of its kind for elderly persons over 55 years of age.

During fiscal year 1988, 4 new community support services programs will begin operation, to include a day program and a transitional shelter, as well as the on sight rehabilitation program for residence of the Mark Well SRO Hotel in Manhattan. Also a day program in Brooklyn and an outpatient clinic in Manhattan, the latter 2 programs having outreach capacity as well.

In the mental retardation development disability center, 3 additional day programs, 2 in Brooklyn and 1 in the Bronx actually have become operational. Proposed initiatives for next fiscal year include 2 additional CSS day programs, 1 in Brooklyn and 1 in Manhattan.

Currently, the department is finalizing a needs assessment and services plan for mental health services to the elderly as well as updating the 1985 directory. The geriatric plan that's used both city wide and borough wide issues and problems involving the delivery of mental health services to the elderly and presents specific priority and recommendations developed in conjunction with the geriatric committee of New York City federation of mental health, mental retardation and alcoholism services which is the department's consumer provided advisory board.

I should mention that Ms. Sullivan who spoke earlier today is an active member of that group and participated in the development of that plan, in addition the Department for the Aging provided a great deal of technical assistance in also participating in the development of this plan which is currently being finalized.

The plan will serve as a basis for future resource allocation through the identification of areas of need for mental health services in New York City, with particular emphasis on the needs of the minority community including identifying bilingual and bicultural capacity.

In the recently passed New York State fiscal 1989 budget, there is increased community support services funding which should

allow a significant program to include services for the geriatric population with some particular focus on day services, to deal with elderly persons who are homeless, as well as ou reach programs into single room occupancy hotels and some of the other locations that have been discussed today.

However, there remains an ever greater need for more significant increases in funding, not only to attempt to keep pace with the growing population, but to address the compounding problems of the elderly. This will warrant and require a Federal Government response to provide leadership in this area.

In closing, the department has identified some following key issues that do effect the delivery of services to the elderly of New York City and that should be considered with the development of legislation and reprogramming.

The development of new day treatment resources has been historically retarded, to the existence of certain regulatory barriers. It is essential to make such changes to allow treatment slots, including attention to the day treatment needs of the mental health system of persons with Alzheimer's.

The elderly constitute a growing proportion of the psychiatric inpatient population of New York City which contributes to the overall overcrowding of that system. There is a need to develop a program resources and to provide incentives and reimbursement systems for the care required on the inpatient level, and then to develop the appropriate nonacute level of care needed so that patients can move from the acute hospital setting into appropriate intermediate long-term care if needed, or residential care or to return to their homes at the appropriate level.

Mobile treatment service for the homebound need to be increased to allow for on going home care and follow up treatment. There is a need to establish more of these programs similar to one run by the committee nurse service which is currently operational in the Bronx.

We would also agree there is a need for more bilingual and cross cultural clinic services for the mentally disabled Spanish as well as Blacks, in particular, this year a program in Lincoln medical center in the Bronx to treat the Hispanic community in the Bronx with a specialized bilingual and bicultural inpatient and outpatient program ha been initiated, and we would also look to develop more such programs over the coming years.

There is a high priority need for the services for the elderly and mentally disabled homeless. In the coming fiscal year, two programs will be established to serve the homeless, but much more is needed.

The New York City department of mental health, mental retardation and alcoholism services is hopeful that the Elderly Mental Health Services Development Act of 1988 will begin a constructive partnership with the Federal, State and local government to improve mental health benefits for all and in particular to recognize and address the special unmet needs of the elderly.

The department is appreciative of the opportunity to share the city's concerns regarding mental health needs of the elderly and I'll be glad to answer any questions you may have.

[The prepared statement of Ms. Kellermann follows:]

SARA L. KELLERMANN, M.D.
COMMISSIONER

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MENTAL HEALTH NEEDS OF THE MENTALLY IMPAIRED ELDERLY OF NEW YORK CITY

SARA L. KELLERMANN, M.D.
COMMISSIONER

Testimony Prepared for Presentation to the
United States House of Representatives/Select Committee on Aging
Queensbridge Houses Community Center, Long Island City.

MAY 13, 1988

I am Sara L. Kellermann, Commissioner of the New York City Department of Mental Health, Mental Retardation and Alcoholism Services. I am honored to have the opportunity to address the United States House of Representatives/Select Committee on Aging. The Department is especially pleased by the Committee's awareness of the acute need for mental health services for the elderly, as evidenced by the introduction of the Elderly Mental Health Services Development and Reform Act of 1988. In its legislative agenda for 1988, the City supported the need for the expansion of the mental health block grant and for the inclusion of "set-asides" for under-served populations' including the elderly. Additionally, the City advocated for the reform of the Medicaid and Medicare systems, which often hinder the effective delivery of services to the elderly.

Background

The Department of Mental Health, Mental Retardation and Alcoholism Services is responsible under the City Charter and the New York State Mental Hygiene Law for the planning, contracting, monitoring and evaluation of all local mental health, mental retardation and developmental disabilities, and alcoholism services in New York City. Currently, the Department administers 750 programs in over 300 voluntary contract agencies, 14 municipal hospitals, the Department of Health,

Family and Criminal Courts, and the Human Resources Administration (HRA). The network of services directly funded and monitored by the Department provides care to more than 425,000 persons each year. Populations served include emotionally disturbed children and youth, the mentally retarded and developmentally disabled, the acutely and chronically mentally ill, alcoholics, persons in need of psychiatric services referred from the courts and prisons, the elderly mentally ill, and the mentally disabled homeless.

The gross budget of all services administered by the Department totals approximately $538 million. This includes approximately $78 million in City Tax Levy, $149 million in several sources of State Funding, $30 million in voluntary agency contributions, and $381 million in client-related revenues. Of the total Department budget, approximately $9 million is allocated to geriatric services.

The Department's findings and experiences in delivering services to the elderly are echoed in the Committee's Report. The Department concurs with the proposed two step strategy. In the short term, mental health services, in general, must be greatly expanded. Over the long term, research must be conducted in order to identify the best methods of providing services to the elderly.

I would like to take this opportunity to briefly mention a few provisions in this initiative which the Department believes will greatly enhance its ability to provide services.

It is widely acknowledged in the health care field that Medicare and Medicaid programs generally provide mental disability benefits inferior to those allowed for physical illnesses. The message to the poor and elderly is that a mental disability is not as significant as a physical illness. The proposed initiative mitigates this inequity by proposing to expand inpatient psychiatric hospital treatment under Medicare Part A to an annual 60 day limit, and removing the current arbitrary cap of 190 life time days. It also lessens the distinctions by allowing beneficiaries 20 outpatient visits annually and reducing the co-payment from a prohibitive 50% to 20%.

The Department is also supportive of an expansion of Medicare and Medicaid coverage for day treatment services: in hospitals, in home-respite care, and for treatment in freestanding mental health clinics. A key element in the reform of the Medicaid program is the proposed requirement that community based mental health services for eligible recipients, including those residing in their homes or in a nursing home, be offered on the same basis as physician coverage.

The Committee has also advanced the objective of developing a long-term strategy to address the mental health needs of the elderly by proposing the establishment of a national mental health education program and authorizing $10 million in funding in 1988 for training for health care professionals, and $22 million for biomedical behavioral and social research on mental illness. The City has long advocated the need for increased funding for research into the causes of mental illness and mental impairment, including those disabilities such as dementia and Alzheimer's disease, which disproportionately afflict the elderly.

The Department would like to commend the Committee for advocating enactment of a health care consumer bill of rights, and including in it the right of all citizens to receive quality treatment regardless of race, religion, gender or creed. Again, the City has supported initiatives that would assure equal access to services for every citizen in its legislative agenda.

Mental Health Services for the Elderly in New York City

In New York City, there are seventy-three specialized geriatric mental health programs serving the elderly. These include thirty-two outpatient clinics, twenty mobile crisis units, fifteen day treatment programs, seven inpatient units,

and an on-site rehabilitation program for elderly residents of the Markwell Hotel. Of the total array, forty programs are funded by the Department, including thirty in the voluntary sector and ten in the New York City Health and Hospitals Corporation, (the municipal hospital sector). These programs provide services to approximately 15,000 elderly persons annually. It should be noted that the elderly are served by all adult mental health service providers - municipal, voluntary non-profit, and private-in New York City.

Growth of the Elderly Population

There are 1,295,531 elderly, 60 years and older living in New York City, representing 18.3 percent of the population. In recent years, the number of those 75 years and over has steadily increased. In addition, the number of elderly minority residents has increased as well.

In New York City as in the United States as a whole, the life span of elderly persons has increased. However, a variety of social, political, medical, and other factors often seem to mitigate the advantages of longevity. For one thing, with the demise of the extended family, more elderly people live alone and below the poverty level; this is especially true for women

and minorities. For another, the greater prevalence of Alzheimer's Disease has strained both the psychological and financial resources of those seeking to cope with caring for spouses or parents and adjusting to inexorable debilitating changes. Also, the resources of many skilled nursing facilities are inadequate to the task, and many facilities will not accept Alzheimer's patients. Finally, third party payment is not responsive to the actual financial costs involved.

In addition, the elderly are increasingly the targets of psychological and physical abuse; and the incidence of alcoholism and drug addiction among the elderly has risen. In New York City, as in some other large cities, the combination of diminished units of rental housing, coupled with the rise in the cost of market rentals, has been castrophic for those elderly on fixed incomes; many have been almost literally "pushed out" of their homes and the housing market.

Department's Response to Growing Needs of Elderly

Over the past ten years, the mental health needs of the elderly have been growing. Research in this field estimates that 25 percent of older people present significant symptoms of mental illness and 10 percent of that group are actually diagnosed as mentally ill.

In addition, the Department through its own planning and needs assessment efforts has documented the growing need for services. In response, the Department launched major efforts to expand mental health services in 1984-85, allocating more than $1.4 million for specialized geriatric programs.

In September, 1985, the Department and the New York City Department for the Aging published a Directory of Mental Health Services for Older Adults in New York City. The purpose of the directory is to serve as a resource and referral source for human service providers who serve the elderly.

In FY 1986-87, the Department provided funding for the expansion of five clinic programs to serve the elderly, two in Queens, one in Brooklyn and two in the Bronx. In FY 1987-88, the Jewish Association for Services for the Aged (JASA), expanded its mobile services in the Bronx to include an Alzheimer's component, and two clinic geriatric components were expanded in Queens and Brooklyn. The Department also implemented a geriatric day program for the developmentally disabled elderly population in Staten Island, the first of its kind for persons over 55 years old.

During FY 1988, four new Community Support Services programs will begin operation, to include a day program in a transi-

tional shelter, an on-site rehabilitation program for residents of the Markwell SRO Hotel in Manhattan, a day program in Brooklyn and an outpatient clinic in Manhattan, with the latter two programs also having c··· .ch capacities. In the mental retardation/developmental disabilities sector, three additional day programs, two in Brooklyn and one in the Bronx will become operational. Proposed initiatives for FY 1989 include two additional CSS day programs, one in Brooklyn and one in Manhattan.

The Department is currently finalizing a needs assessment and services plan for mental health services to the elderly, as well as updating the 1985 Directory of Mental Health Services for Older Adults in New York City. The geriatric plan reviews both Citywide and borough-wide issues and problems involving the delivery of mental health services to the elderly, and presents borough specific priorities and recommendations developed in conjunction with the Geriatric Committee of the New York City Federation of Mental Health, Mental Retardation and Alcoholism Services, the Department's consumer/provider advisory group. The geriatric services plan will serve as a basis for future resource allocation through the identification of areas of need for mental health services in New York City. This will include programs with bi-lingual and bi-cultural capacities to provide services to minority individuals.

In the FY 89 New York State Budget, increased CSS funding should allow for significant program growth, to include services for the geriatric population, with emphasis on providing a variety of residential and day services to deal with the special needs of individuals who are both homeless and mentally ill, as well as in SRO hotels and drop-in centers.

However, there remains an even greater need for more significant increases in funding, not only to attempt to keep pace with the growing population, but to address the compounding problems of the elderly that exist. This will warrant and require a greater federal government response to provide leadership in this area.

Key Issues Affecting Delivery of Services

The Department has identified the following key issues that affect the delivery of services to the elderly of New York City:

- There is no specific continuum-of-care mechanism to allow for free movement among the modalities of care. The Department recommends that emphasis be

made for the provision of more comprehensive and better coordinated services through increased collaboration among agencies and providers, as well as expansion of existing services and the development of new services or configuration of services where needed.

- Development of new day treatment resources has been retarded due to lack of regulatory changes and cost-based rate adjustments. It is essential to make such changes allowing for additional day treatment slots, to include Alzheimer's components.

- The elderly constitute a proportionally higher percentage of the current psychiatric inpatient population, contributing to overcrowding in the psychiatric services system in New York City. There is a need to develop appropriate resources and to provide incentives in reimbursement systems for the care required.

- There is an inadequate number of long-term beds for dual physical and psychiatric diagnosis, warranting the need for additional the construction of beds.

- Mobile treatment services for the homebound and frail need to be increased, allowing for on-going home care and follow-up treatment. There is a need to establish more in-home programs, similar to that of the Visiting Nurse Service, In-Home Geriatric Program, which became operational this year in the Bronx.

- There exists the need for more bi-lingual and cross-cultural clinic services for mentally disabled Hispanics, such as the model program at Lincoln Medical and Mental Health Center.

- A high priority need is that of the elderly mentally disabled homeless. In FY 1989, two programs will be established to serve the homeless, but more are needed.

The New York City Department of Mental Health, Mental Retardation and Alcoholism Services is hopeful that the Elderly Mental Health Services Development Act of 1988 will begin a constructive partnership of the federal, state and local governments to improve mental health benefits for all, and in particular, to recognize and address the special unmet needs of the elderly.

The Department is appreciative of the opportunity to share the City's concerns regarding mental health needs of the elderly. I will now answer any questions you may have regarding the City's testimony.

Thank you.

The CHAIRMAN. The Chair will now recognize Dr. Casimir. May I say that I would like to welcome you to this committee? I know of your work with the Kingsboro Psychiatric Center here in New York. I compliment you for the work you're doing and ask you to proceed in any manner that you desire.

STATEMENT OF GEORGES CASIMIR, M.D., CHIEF, GERIATRIC SERVICES, KINGSBORO PSYCHIATRIC CENTER, NEW YORK, NY

Dr. CASIMER. Thank you. It is my pleasure to present this testimony to the United States House of Representatives Select Committee on Aging on behalf of the New York State Office of Mental Health. My commissioner, Dr. Richard Surles, joins me in applauding the attention given by the committee to the mental health needs of the elderly. I am particularly pleased to know that these hearings will focus in part on the special needs of minority elderly.

Let me begin my remarks by supporting your emphasis on the development of community based services for the elderly with mental impairments. Based on my practice with the elderly mentally ill in both inpatient and outpatient settings, I recognize that most of the elderly in need of mental health services are in the community either living alone or with family members. Clearly, we need to foster the development of a continuum of psychogeriatric services from community based prevention focused on reducing social isolation to highly structured inpatient services for the seriously mentally ill, with the full range of service options in between. I would like to see New York State move toward an integrated service continuum. In such a continuum the same staff serve the geriatric patient from the point of first contact, through admission if necessary, and back into the community with appropriate plans for discharge and followup. The emphasis on continuity of service provision by a core staff who know the patient's history and have worked with the patient over time, through both acute and chronic phases of the illness. I believe that services delivered in this manner will reduce the number of rehospitalizations characteristic of patients who flounder in the fragmented system we currently have.

The New York State office of mental health is beginning to take steps to foster this continuum of services through its intensive case management initiative. These patients targeted, among them elderly, will have access to a case manager 24 hours a day, 7 days a week to assure that they receive appropriate treatment and the necessary support services to be maintained in the least restrictive environment consistent with their individual needs.

The case managers will be helpful in assisting the elderly mentally ill to overcome several barriers to accessing needed services. I would like to specifically address some of those barriers and make some suggestions for ameliorative strategies.

For the elderly mentally ill who also have significant medical, nursing and personal care needs, gaining access to nursing home care in this State is difficult. Nursing homes appear to discriminate against patients with a history of mental illness, even when their physical needs are such that skilled nursing services are required.

The patient review instrument, PRI, which is the screening device used in this State to score patients being considered for nursing home admission gives greater weight to the medical needs of the patient, as compared to the psychiatric needs. Patients with the combination of medical and psychiatric illness are clearly the most complex cases. Until assessment tools and their related reimbursement mechanisms are refined enough to capture this complexity and provide financial incentives for the care of these patients, they will continue to be rejected by nursing home operators.

A related problem is the number of SNF—skilled nursing facilities—eligible patients residing in State psychiatric centers who would more appropriately be cared for in a skilled nursing facility or health related facility. The unwillingness of nursing homes to take these patients results in their blocking beds in State hospitals which are needed by individuals who require inpatient psychiatric treatment. The New York State office of mental health and the New York State department of health have begun to discuss ways to resolve this problem.

The provisions in your reform act related to review of reimbursement levels under Medicare and Medicaid programs to ensure that reasonable amounts are provided for the provision of mental health services should help to provide for the incentive of nursing homes to more readily accept individuals with mental impairments who also require skilled nursing care.

A significant proportion of nursing home residents suffer from one or more mental impairments. Yet few nursing homes provide any diagnostic treatment or rehabilitative mental health services. Patients with Alzheimer's disease and related dementias are particularly underserved. Nursing homes must be required to provide mental health services to their residents who need such services, and should be expected to enhance staff training and linkages with the mental health system to facilitate the delivery of such services.

Because inpatient care, whether psychiatric or medical is so costly, we spend a great deal of time discussing these types of services. It is easy to forget that the vast majority of persons with disabilities of any kind are residing in the community. I am therefore pleased with the emphasis on community based mental health services in Chairman Roybal's proposal. There are several issues of concern to me related to community based psychogeriatric services.

One of them is housing and mental health support services. In my opinion, the lack of adequate and affordable housing especially in New York City is a precipitating factor for mental distress for persons of all ages, especially the elderly.

As older neighborhoods are gentrified, older residents are displaced to seek affordable and usually substandard housing on their own, or to seek shelter with children, or worse to live in the streets among our growing homeless population.

Depression, isolation and disorientation are frequently the result, especially for those without family to rely upon. Some of these older refugees will frequent emergency rooms and others will ultimately come to the psychiatric facilities when all other systems have failed.

Clearly we need to assure that at risk-elderly, especially those who are poor and members of minority groups, have access to ap-

propriate housing. Once in such housing, mechanisms need to be in place to link elderly with mental health needs to appropriate mental health services in their communities of residence.

A special area of concern is the aging in of residents of senior citizens' housing. Having entered such housing as relatively healthy and independently functioning individuals, these individuals become increasingly physically and mentally frail after 10 to 20 years of residence.

We must develop mental health services which reach into senior housing to assist residents in coping with some of the inevitable deficits with accompany old age.

Kingsboro Psychiatric Center has a team that goes into a senior center in Bushwood and Ridgewood of Brooklyn where there resides heavily Hispanic population and we've had very good success in this area.

One would think that a community mental health center should be a logical site for such linkages, but we know that the elderly and racial ethnic minorities significantly underutilize community mental health centers.

I am pleased to see that your act directs that a study be undertaken to examine the representation of racial and ethnic minorities among persons receiving community mental health center services and to encourage demonstration projects to better serve this population.

It is my hope that special attention be given to identification of the needs of elderly mentally ill from racial and ethnic minority groups and how community mental health centers might better serve this group. In addition, I would like to see demonstration projects focus on the use of mobile geriatric assessment and treatment services which have added flexibility of taking services to sites where the elderly reside.

I have had the opportunity to work with two mobile geriatric units in Brooklyn. One in Kingsboro Psychiatric Center and one as part of Bedford Styvestant community mental health center. I think there's a lot more needed in this area. Over the years instead of expanding, we've seen it diminishing as far as mobile geriatric assessment and treatment center services are concerned.

Support for family members who are caring for the elderly mentally ill at home needs to be expanded. It has been my observation that many of the caregivers of the elderly mentally ill are themselves elderly. They are coping with their own aging issues, while valiantly attempting to meet the needs of loved ones. Your provision for Medicare coverage of in home respite is the type of assistance family caregivers need.

I also worked with the community of mental health center of Maimonides medical center where you have a lot of Jewish but also a lot of Hispanic people, and a lot of times these patients come to the programs, but they only come for a few hours a week and the families do need a lot of time to rest and take care of their own responsibilities and we have found that when they become really tired of taking care of a sister or a brother or a spouse, sometimes we give them a good opportunity to really rest and do what they would like to do by seeing the patients to respite houses even for 2

or 3 days. And maybe in your proposal you can extend the number of days that can be afforded to this particular program.

Family members also need education regarding normal aging, as well as signs and symptoms of mental distress or mental illness among the elderly.

The New York State office of mental health recently funded several demonstration projects addressing the psycho education and family support needs of the family caregivers of the mentally ill from various racial and ethnic minority groups, including Blacks, Puerto Ricans, Vietnamese and native Americans on the Mohawk Indian reservation.

Family support can be enhanced by the provision of adult day-care and day treatment programs which create rehabilitation and socialization opportunities for mentally impaired elderly while giving the family respite for several hours a day. Participation in such programs appears to decrease isolation and related depression among the elderly.

Transportation services is also a critical area. It is critical that transportation services be made available to program participants, especially those who are above Medicaid eligibility, but still too poor to pay for routine transportation from their own resources.

As part of my work with mobile geriatric units, I do visit patients in their homes; however, sometimes I would like to offer other programs to the patients. We don't have too many of these programs in Brooklyn and one of the problem associated with that is transportation. Sometimes the patient may have the means to go to the program; however no transportation is available because the patient is too far from where the services are provided.

It is my opinion that elderly mentally ill can be maintained in the community and their own homes with increased access to generic home care services, including home health care, personal care, housekeeping and chore services. Many home care providers are reluctant to serve individuals with a history of mental illness. Home care workers are not adequately trained to work with clients whose behavior may be unpredictable and disruptive.

Special training is needed for home care workers who are willing to take care of the elderly who are demented or have other serious mental illness. In order to increase the supply of workers who are so trained, consideration should be given to special certification and related compensation and benefit packages for workers willing to serve the more complex patient.

I will mention some of my personal experiences. When I make home visits and when I receive elderly patients in my clinics, you would not believe how much time is spent talking about what they've been through with the last home care worker they had. Half of the session I spend listening to these complaints. I think there is a lot that needs to be done in this area, particularly in the area of training these people and providing the incentive. This way we'll be able to attract better qualified people to provide services.

The expansion for adult day services for at risk elderly, including those with mental health impairments, was the subject of a major policy analysis last year by Governor Cuomo's long-term care policy coordinating council. Your provisions for expanded outpatient benefits under Medicare part B for day hospitalization and

day treatment activities will help to insure that elderly with more serious mental impairments will be able to take advantage of these types of services.

I happen to be a consultant for three programs in Brooklyn—the one in Maimonides medical center, the one in Brooklyn Jewish Hospital and Metropolitan Jewish. Most of them are unavailable to go because they only have Medicaid and they don't have any Medicare provision that would facilitate their entry to such programs, and I think your provisions are very excellent in this area.

The reluctance of some providers to serve the elderly mentally ill may be explained in part by their lack of skill in working with this population. Provider training in psychogeriatrics and the management of the mentally ill older person is needed at all staff levels. Understanding of the causes of disturbing behaviors and how they can be managed will help to lessen negative staff perceptions. Such training can also help staff to set realistic treatment and rehabilitation goals for the older patient.

Physicians, especially family practitioners and internists, are frequently the first points of contact for mentally at risk elderly whose somatization of emotional distress causes them to seek medical attention. Such patients are also known to nurses and emergency room staff, particularly in our large urban centers.

These staff must be better trained to recognize early signs of mental distress, as well as more serious psychiatric illness and treat and/or refer patients appropriately. The provision in your act for increased training of professionals at all levels, with special attention to members of racial ethnic minority groups, in order to improve the prevention, diagnosis, treatment and management of mental disorders among the elderly is excellent and much needed.

The office of mental health, in cooperation with the department of psychiatry, State university of New York Health Science Center in Brooklyn, and Kingsboro Psychiatric Center, is undertaking a project to develop a model in State hospitals for teaching skills in psychogeriatrics to an interdisciplinary team of trainees for psychiatry, nursing, occupational therapy, psychology and social work. Training will focus on assessment, treatment, and discharge planning of patients in psychogeriatric units.

Through enhancing knowledge and clinical skills in an interdisciplinary context, it is believed that both staff morale and quality of clinical care provided to older patients will be improved. In addition, the project hopes to demonstrate the mutual benefits that can be derived from collaborations between an academic center and State hospital facility.

I happen to be at one of the coordinators at the program I'm mentioning here, and right now while I'm talking to you, there is a conference that's being provided to social workers. As part of my job as Chief of Geriatric Services at Kingsboro Psychiatric Center, and also assistant director of geriatric program, I happen to provide a lot of teaching to both medical students, psychiatric residents and fellows in geriatric psychiatry and also residents in family practice and it's really important that internists and family practitioners be incorporated into such training programs because the patients usually go to the internist and the family physician

before coming to a psychiatrist and most of the time they are not properly treated or properly referred especially in this area.

I'd also like to mention that I'm very lucky to have been the first graduate of a geriatric fellowship program at Downstate which was a federally funded program. Funding in this area has been stopped and at that time I was a fellow, there were only two such programs in the New York State area, maybe eight or nine in the whole country.

I was very pleased while I was at the annual convention of the American Psychiatric Association to have met about 20 directors of such programs. Although more programs are needed and more programs are being built, funding in this area has dwindled considerably.

Finally, let me applaud the additional funding proposed for research initiatives related to biomedical, behavioral, and social research on prevention and treatment services. There is much that is yet to be learned about the etiology of mental illness in the elderly and their special treatment requirements. This is particularly true for elderly who are racial and cultural minorities where the definition of mental illness, its causes and its treatments can vary markedly from mainstream clinical perceptions.

We are fortunate to have two distinguished research facilities within our system—Nathan S. Kline Institute and the New York Psychiatric Institute. It is my hope that these nationally recognized institutes will give increased attention to the study of prevalence and patterns of mental illness among the elderly.

The availability of additional research funds, such as those you propose Mr. Chairman, significantly increases the chances that the needs of the mentally ill elderly will become a priority for further inquiry.

On behalf of the New York State office of mental health, Commission Richard Surles, and the elderly mentally ill of New York State, I would like to thank you for this opportunity to participate in these hearings. We look forward to the timely enactment of the Elderly Mental Health Services Development and Reform Act of 1988 and the benefits we envision resulting from it.

Thank you very much.

[The prepared statement of Dr. Casimer follows:]

TESTIMONY OF GEORGES CASIMIR, M.D.

Chief, Geriatric Services
Kingsboro Psychiatric Center

Presented at Hearings Held by the
U.S. House Select Committee on Aging
on Mental Health Needs of the Elderly

May 13,1988

Queens, New York

Testimony of Georges Casimir, M.D.
Kingsboro Psychiatric Center, NYC

It is my pleasure to present this testimony to the U.S. House of Representatives Select Committee on Aging on behalf of the New York State Office of Mental Health. My Commissioner, Dr. Richard Surles, joins me in applauding the attention given by the Committee to the mental health needs of the elderly. I am particularly pleased to know that these hearings will focus, in part, on the special needs of minority elderly.

Let me begin my remarks by supporting your emphasis on the development of community-based services for the elderly with mental impairments. Based on my practice with the elderly mentally ill in both inpatient and outpatient settings, I recognize that most of the elderly in need of mental health services are in the community either living alone or with family members. Clearly we need to foster the development of a continuum of psychogeriatric services from community-based prevention focused on reducing social isolation to highly structured inpatient services for the seriously mentally ill, with the full range of service options in between. I would like to see New York State move toward an integrated service continuum. In such a continuum the same staff serve the geriatric patient from the point of first contact, through admission if necessary, and back into the community with appropriate plans for discharge and follow-up. The emphasis is

on continuity of service provision by a core staff who know the patient's history and have worked with the patient over time, through both acute and chronic phases of the illness. I believe that services delivered in this manner will reduce the number of rehospitalizations characteristic of patients who flounder in the fragmented system we currently have.

Intensive Case Management

The New York State Office of Mental Health is beginning to take steps to foster this continuum of services through its Intensive Case Management Initiative. Although not specifically targeted for the geriatric population, this initiative does focus on the small number of chronically mentally ill who are the very high utilizers of system resources. There will be elderly persons in this target group. These patients will have access to a case manager 24-hours a day, 7 days a week to assure that they receive appropriate treatment and the necessary support services to be maintained in the least restrictive environment consistent with their individual needs.

These case managers will be helpful in assisting the elderly mentally ill to overcome several barriers to accessing needed services. I would like to specifically address some of those barriers and make some suggestions for ameliorative strategies.

Access to Skilled Nursing Care

For the elderly mentally ill who also have significant medical, nursing and personal care needs, gaining access to nursing home care in this state is difficult. Nursing homes appear to discriminate against patients with a history of mental illness, even when their physical needs are such that skilled nursing services are required. The Patient Review Instrument (PRI) which is the screening device used in this state to score patients being considered for nursing home admission gives greater weight to the medical needs of the patient, as compared to the psychiatric needs. Patients with the combination of medical and psychiatric illness are clearly the most complex cases. Until assessment tools and their related reimbursement mechanisms are refined enough to capture this complexity and provide financial incentives for the care of these patients, they will continue to be rejected by nursing home operators.

A related problem is the number of SNF-eligible patients residing in state psychiatric centers who would more appropriately be cared for in a SNF or HRF. The unwillingness of nursing homes to take these patients results in their "blocking" beds in state hospitals which are needed by individuals who require inpatient psychiatric treatment. The New York State Office of Mental Health and the New York State Department of Health have begun to discuss ways to resolve this problem.
The provisions in your Reform Act related to review of

reimbursement levels under Medicare and Medicaid programs to ensure that reasonable amounts are provided for the provision of mental health services should help to incentivize nursing homes to more readily accept individuals with mental impairments who also require skilled nursing care.

A significant proportion of nursing home residents suffer from one or more mental impairments. Yet, few nursing homes provide any diagnostic, treatment, or rehabilitative mental health services. Patients with Alzheimer's disease and related dementias are particularly underserved. Nursing homes must be required to provide mental health services to their residents who need such services, and should be expected to enhance staff training and linkages with the mental health system to facilitate the delivery of such services.

Community-Based Services

Because inpatient care, whether psychiatric or medical, is so costly, we spend a great deal of time discussing these types of services. It is easy to forget that the vast majority of persons with disabilities of any kind are residing in the community. I am, therefore, very pleased with the emphasis on community-based mental health services in Chairman Roybal's proposal. There are several issues of concern to me related to community-based psychogeriatric services.

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Housing and Mental Health Support Services

In my opinion, the lack of adequate and affordable housing (especially in New York City) is a precipitating factor for mental distress for persons of all ages, especially the elderly. As older neighborhoods are "gentrified", older residents are displaced to seek affordable and usually substandard housing on their own, or to seek shelter with children, or worse to live on the streets among our growing homeless population. Depression, isolation, and disorientation are frequently the result, especially for those without family to rely upon. Some of these older refugees will frequent emergency rooms and others will ultimately come to the psychiatric facility when all other systems have failed.

Clearly we need to assure that at-risk elderly, especially those who are poor and members of minority groups, have access to appropriate housing. Once in such housing, mechanisms need to be in place to link elderly with mental health needs to appropriate mental health services in their communities of residence. A special area of concern is the "aging-in" of residents of senior citizen's housing. Having entered such housing as relatively healthy and independently functioning individuals, these individuals become increasingly physically and mentally frail after 10 to 20 years of residence. We must develop mental health services which reach into senior housing to assist residents in coping with some of the inevitable deficits which accompany old age.

One would think that Community Mental Health Centers would be a logical site for such linkages, but we know that the elderly and racial/ethnic minorities significantly underutilize CMHCs. I am pleased to see that your Act directs that a study be undertaken to examine the representation of racial and ethnic minorities among persons receiving CMHC services and to encourage demonstration projects to better serve this population. It is my hope that special attention be given to identification of the needs of elderly mentally ill from racial and ethnic minority groups and how CMHC's might better serve this group. In addition, I would like to see demonstration projects focus on the use of mobile geriatric assessment and treatment services which have the added flexibility of taking services to sites where the elderly reside.

Family Support and Family Psychoeducation

Support for family members who are caring for the elderly mentally ill at home needs to be expanded. It has been my observation that many of the caregivers of the elderly mentally ill are themselves elderly. They are coping with their own aging issues, while valiantly attempting to meet the needs of loved ones. Your provision for Medicare coverage of in-home respite is the type of assistance family caregivers need. Family members also need education regarding normal aging, as well as signs and symptoms of mental distress or mental illness among the

elderly. Peer support for family caregivers of the mentally ill elderly needs to be encouraged. Family psychoeducation and family counseling should be components of community-based and institutional psychogeriatric programs.

The New York State Office of Mental Health recently funded several demonstration projects addressing the psychoeducation and family support needs of family caregivers of the mentally ill from various racial and ethnic minority groups, including Blacks, Puerto Ricans, Vietnamese, and Native Americans on the Mohawk Indian Reservation.

Family support can be enhanced by the provision of Adult Day Care and Day Treatment programs which create rehabilitation and socialization opportunities for cognitively or mentally impaired elderly, while giving the family respite for several hours a day. Participation in such programs appears to decrease isolation and related depression among the elderly.

Transportation Services

It is critical that transportation services be made available to program participants, especially those who are above Medicaid eligibility, but still too poor to pay for routine transportation from their own resources. This applies not only to mental health services, but transportation to physician's offices, medical clinics, and social activities.

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Home Care Services

It is my opinion that elderly mentally ill can be maintained in the community and their own homes with increased access to generic home care services, including home health care, personal care, housekeeping and chore services. Many home care providers are reluctant to serve individuals with a history of mental illness. Home care workers are not adequately trained to work with clients whose behavior may be unpredictable and disruptive. Special training is needed for home care workers who are willing to take care of the elderly who are demented or have other serious mental illness. In order to increase the supply of workers who are so trained, consideration should be given to special certification and related compensation and benefit packages for workers willing to serve the more complex patient.

Under the aegis of the Governor's Long Term Care Policy Coordinating Council, a study is being undertaken of factors related to the recruitment, training, and retention of home care workers in New York State. Issues related to the care of clients with mental impairments are addressed in the survey instrument and the results should help us to better develop a strategy to increase the cadre of workers willing to serve our population in their own homes.

Adult Day Services and Day Treatment Programs

The expansion of Adult Day Services for at-risk elderly,

including those with mental impairments, was the subject of a major policy analysis last year by Governor Cuomo's Long Term Care Policy Coordinating Council. The Office of Mental Health is a member agency of the Council and actively participated in the preparation of the policy document on Adult Day Services in New York State. Your provisions for expanded outpatient benefits under Medicare Part B for day hospitalization and day treatment activities will help to insure that elderly with more serious mental impairments will be able to take advantage of these types of services.

Training Issues

The reluctance of some providers to serve the elderly mentally ill pay be explained, in part, by their lack of skill in working with this population. Provider training in psychogeriatrics and the management of the mentally ill older person is needed at all staff levels. Understanding of the causes of disturbing behaviors and how they can be managed will help to lessen negative staff perceptions. Such training can also help staff to set realistic treatment and rehabilitation goals for the older patient.

Physicians, especially family practitioners and internists, are frequently the first points of contact for mentally at-risk elderly whose somatization of emotional distress causes them to seek medical attention. Such patients are also known to nurses and emergency room staff, particularly in our large urban

centers. These staff must be better trained to recognize early signs of mental distress, as well as more serious psychiatric illness and treat and/or refer patients appropriately. The provision in your Act for increased training of professionals at all levels, with special attention to members of racial and ethnic minority groups, in order to improve the prevention, diagnosis, treatment and management of mental disorders among the elderly is excellent and much needed.

The Office of Mental Health, in cooperation with the Department of Psychiatry, State University of New York Health Science Center at Brooklyn and Kingsboro Psychiatric Center, is undertaking a project to develop a model in state hospitals for teaching skills in psychogeriatrics to an interdisciplinary team of trainees from psychiatry, nursing, occupational therapy, psychology, and social work. Training will focus on assessment, treatment, and discharge planning of patients in psyhogeriatric units. Through enhancing knowledge and clinical skills in an interdisciplinary context, it is believed that both staff morale and quality of clinical care provided to older patients will be improved. In addition, the project hopes to demonstrate the mutual benefits that can be derived from collaborations between an academic center and state hospital facility.

Research

Finally, let me applaud the additional funding proposed for research initiatives related to biomedical, behavioral, and

social research on prevention and treatment services. There is much that is yet to be learned about the etiology of mental illness in the elderly and their special treatment requirements. This is particularly true for elderly who are racial and cultural minorities where the definition of mental illness, its causes, and its treatments can vary markedly from mainstream clinical perceptions.

We are fortunate to have to distinguished research facili' s within our system: the Nathan S. Kline Institute and the New York Psychiatric Institute. It is my hope that these nationally recognized Institutes will give increased attention to the study of prevalence and patterns of mental illness among the elderly, along with applied studies that will help to increase effectiveness in design and delivery of services to the psychogeriatric population. The availability of additional research funds, such as those you propose, significantly increases the chances that the needs of the mentally ill elderly will become a priority for further inquiry.

On behalf of the New York State Office of Mental Health, Commissioner Richard Surles, and the elderly mentally ill of New York State, I would like to thank you for this opportunity to participate in these hearings. We look forward to the timely enactment of the Elderly Mental Health Services Development and Reform Act of 1988 and the benefits we envision resulting from it.

SUMMARY OF RECOMMENDATIONS

o Development and implementation of an integrated service continuum for geriatric mentally ill patients to reduce fragmentation in service delivery and reduce unnecessary hospitalizations.

o Enhance intensive case management services for the elderly mentally ill.

o Reduce policy and fiscal barriers to accessing skilled nursing facilities for mentally ill elderly with significant medical and nursing care needs.

o Provide mental health services to nursing home residents.

o Increase the availability of affordable and safe housing for the elderly with back-up mental health and other supportive services as needed.

o Require Community Mental Health Centers to increase their services to elderly, especially those from racial and ethnic minority groups. Special emphasis should be placed on outreach services and the development of mobile geriatric diagnostic and treatment teams.

o Increase respite and family psychoeducation services to caregivers of the elderly mentally ill.

o Increase transportation services to the elderly to enhance their ability to access needed services and to reduce the physical isolation which leads to depression.

o Increase in-home supportive services to the elderly mentally ill in order to enhance their chances of being successfully cared for in the community.

o Increase the availability of adult day care and day treatment services for the elderly mentally ill.

o Enhance the opportunities for mental health providers at all levels to receive specialized training in psychogeriatric assessment and treatment. Such training should include attention to cultural and ethnic factors which influence the prevalence of mental disorders among the elderly, as well as their use of mental health services.

o Expand research activities which focus on the etiology, diagnosis, and treatment of mental disorders among the elderly, with special attention to racial and ethnic differences.

The CHAIRMAN. I'd like to compliment you and Mr. Kastan for very excellent testimony and call on Congressman Manton to start the questions.

Mr. MANTON. Thank you Mr. Chairman. I would like to commend both of our panelists for excellent testimony. Dr. Casimer, you have been very specific in your list of recommendations and very comprehensive ranging from calling for a continuum of geriatric care for mentally ill patients to reduce the fragmentation and reduce policy and fiscal barriers, to providing mental health services to nursing home residents. You've talked about respites for family members and such mundane things that have become very important as transportation, affordable housing, adult daycare treatment and specialized training, et cetera. All of these things obviously are areas that should be and must be improved.

Are there any of these recommendations that you see as more important than the others, and things that if we have a limitation of resources, that we should prioritize?

Dr. CASIMER. Yes. I will probably be biased because for the last 2 years I've been working for elderly patients, I have always had in mind this integrated service continuum. I was very pleased last week while reading Chairman Roybal's proposal to see that there was a similar program being proposed, and I'm also very pleased while meeting with the Commissioner Dr. Richard Surles, last Friday, to also hear that he's been leaning in this direction.

I've been working with the elderly in different environments. It just happened that the borough of Brooklyn is not such a big area, and I happened to work with at the Kingsboro Psychiatric Center on an in patient geriatric unit and I also provide my services with two mobile geriatric units with adult homes and adult day programs and also outpatient clinics, and I do provide 4 hours here, 10 hours there and so on.

We have a case at Kingsboro Psychiatric Center. The patient was in an adult home and was going to another day program. That morning, I was at Maimonides when the social worker in the day program called me and said this patient is decompensated. Right away, I called the other home and the other social worker who works with this patient was there, so we called the ambulance and this patient was taken to Kingsboro Hospital.

This is somebody who has been decompensating gradually over a period of 6 weeks and who have tried to keep in the community, successfully, until she reached a point where she could not anywhere. The only reason why she was going to be kept so long in the community is because of all the resources, all the services that were brought to her by social workers and physicians.

In the inpatient service, we knew exactly what medication she was on, what kind of services that we can provide for her. I think continuum of service, if that can be expanded on a wider scale, would be the best thing we could as far as providing services for mentally ill elderly patients.

Mr. MANTON. Thank you. I have a question for Mr. Kastan. You mentioned in your testimony that the department is moving toward specifically targeting programs to address the mental health needs of the minority elderly. Would you want to expand on that a bit?

Mr. KASTAN. Sure. In general, I think the department is developing programs throughout the city, clearly targeted to services to those communities where minority and poor people are located. I think that in coming here, we had some proposals to enhance the capacity of our clinics to develop a better capacity to serve minority individuals, both by increasing the service, but also by equipping them with a training capacity. In the coming fiscal year, they'll be some new day treatment programs targeted to the elderly in a minority community.

I think there are quite a few things going on in the coming year.

Mr. MANTON. Thank you. I give back the mike to the Chairman.

The CHAIRMAN. Thank you. I'd like to again compliment you on your testimony. I think the hearing has been excellent.

I would like to ask a question of Dr. Casimer, and this is very closely related to the emphasis that is placed by other people testifying on the value of taking services to the community.

At one time I was in the field of health education and was in charge of the first X-ray mobile unit put out in this Nation back in 1940 that dealt with free chest X-rays, and we thought at that time, the eradication of tuberculosis.

When you mentioned the need for mobile geriatric assessment and treatment services, it immediately brought back old memories and those things that we did at that time. But you mentioned that these treatment services would be provided in sites where the elderly reside, which goes back to the testimony given by others that we can make services available to the people in their own neighborhoods.

Can you tell the committee how these services will be structured; one, with regard to professional staffing, and; two, what functions would such a mobile geriatric treatment services provide or undertake?

Dr. CASIMER. In terms of staffing, I would say that the better staff, the more staff the better. The more staff in terms of different disciplines being on staff.

What I have noticed in the mobile geriatric teams that I have worked with is the fact that they have more social workers than anything else. They did not have enough physicians, enough nurses—and I mean psychiatrists and medical specialists. I would like to see the staff being composed of represented by all disciplines of mental health.

We would like to have other outreach sources—neighbors, churches and landlords—people who should be somehow trained to identify the first signs of mental distress and bring that to the mental health professionals, the mobile geriatric team. When we go, our job is to identify the program and then go on from there.

Often, we may have to take more drastic measures by putting this patient in the hospital, so that's where good training of this mental health professional may held them know exactly what particular measures must be taken.

The CHAIRMAN. In your description of the team involved in identifying the problem, you mentioned social workers and other professionals in that related field. You didn't mention psychologists. Was that left out inadvertently or is a psychologist not considered to be part of this team that identifies problems?

Dr. CASIMER. A good psychologist can do a job as good as a social worker in this area. However, when it comes to going to the site to identify this crisis, a psychologist may not at this point be as useful as some of the participants I just mentioned. Not that they cannot provide the services, but as far as going into the community to the patient's house and identifying the problem and resolving it—the psychologist may not be as useful.

However, on the other side of the fence, on the inpatient unit, the psychologist service is very useful and I strongly encourage the present trend of having psychologists in hospitals, to continue following the patients that they have on the outside.

The CHAIRMAN. I wish I could pursue this a little further, but time will not permit it.

I'd like to ask a question in regard to a statement that you made, Mr. Kastan, in which you said in general that the city of New York spends approximately $638 million in general services on mental hygiene. You also stated that 18 percent of the population in New York City is 60 years of age and older, but that the amount of money that you spent on services to the elderly is in the neighborhood of $9 million which is 1½ percent of the total amount.

Can you tell me how or why that is done?

Mr. KASTAN. The department's overall gross budget is in fact $638 million. It includes city tax levy, State funding, voluntary contributions as well as revenues.

The $9 million figure does in fact to refer to the specialized geriatric services that I have referred to. In addition, the elderly are served throughout the mental health system department funds in adult clinics, in patient units, day programs.

We do know from the State office of mental health patient care survey that approximately 15 to 17 percent of the individuals served by mental health programs in any given week are in fact elderly.

Which I think clarifies a little bit clearly much more needs to be done, but I think we are addressing a greater portion of the need for services.

The CHAIRMAN. The inference I got from that statement did lead me to think and reaffirm the conclusion that I seem to come to, and that is whether it is the Federal Government, the State or the local health department, not enough is being done in this field.

What recommendation do you have or would you make to this committee that we write into legislation that would help you do a better job with the senior citizen community?

Mr. KASTAN. I'm going to let Marla Degotta who is a staff person in my office who has special responsibilities with the elderly address that question.

Ms. DEGOTTA. I think the present bill that you're working on a far as the expansion of Medicaid and Medicare is very important, but as you mentioned $9 million doesn't seem to be a lot of money and it really isn't. We need expansion of funds and that's why it's so important—just because you get the money doesn't mean that the services are going to become better.

That's why we took on this needs assessment, because in New York City there really hasn't been a valid needs assessment done,

when we do get enough monies where are we going to allocate those in a specific area.

The biggest thing are the current legislative issues that we are working on, but we need the monies so we can provide more geriatric programs. Just a simple day treatment program, the cost is approximately over $360,000. That's a lot of money but it's still not enough.

We do need a lot more influx of money because a lot of tnis $600 million is just trying to maintain our contract agency's presently and about 750 clinics, et cetera.

The CHAIRMAN. We did have a White House Conference on Aging and I hope that the next conference will give an opportunity to actually not only make recommendations but to be able to make those recommendations to the areas that you represent.

Coming back to what it is that we can do, we have legislation that looks promising, but we can't do a thing unless we have some help. For example, the appropriation that has been made available for health, in general, has in fact been put in place at great jeopardy since the administration has recommended reductions. We in the Appropriations Committee came in with a recommendation that was at least $5.7 billion more, which simply means that the administration recommended a reduction of $5.7 billion for health and education.

When that subject matter was being discussed, I asked the following question of the Chairman of the Appropriations Committee. I want to know how many letters we have received from around the country protesting the fact that the administration had attempted to reduce the budget by that amount.

The clerk handed us 37 letters from all over the country, which simply meant that there are only 37 people who are interested. Six of those letters came from my own district from senior citizens who were protesting the fact that Social Security was going to be placed in private industries.

I bring that to your attention because I firmly believe that we in Congress cannot do anything unless we have some help from you. I hope that if you're really interested in this piece of legislation or the recommendation that this committee will make, that you not only let us know about it, but also the President regardless of who it happens to be, the Secretary of Health and Human Services, and those department heads in Washington who are responsible for the distribution of money. Let them know about it!

This is the only way that I believe that we can get these monies that you are telling this committee that you need. We cannot do anything that you don't permit us to do and you don't help us with.

I think the value of this discussion has been that we've learned a great deal from you. We know your problems, but I also want to take this opportunity to tell you about our problems. We need your help. Please write to the President, write to the department heads, write to your Congressman, particularly if he has been known to move against Federal health and education. Let them know that the people in general want some changes.

I would like to again take this opportunity to thank Mr. Kastan and Dr. Casimer for your excellent testimony and we will try to

reduce this in writing to a report that we hope will meet with your approval and your support.

I thank you very much.

Ms. DEGOTTA. When might that report be coming out?

The CHAIRMAN. The report will come out the end of August. We are going to go to Denver on the 27th of May. Then we'll go to Los Angeles on July 8th. When we get all this testimony accumulated and analyzed, we will then write the final report. We hope to send each and every one of you who have testified, a copy of that report.

Again, thank you all very much. The hearing is now adjourned.

[Whereupon, at 1:02 p.m. the hearing was adjourned.]

APPENDIX

Mental Health and the Black Elderly

Written by: Melvina Missouri-Donovan, M.S., R.N.,C.
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According to the report of the Mini-Conference on Black Aged prepared for the 1981 White House Conference on Aging, mental health services for elderly Black Americans are limited and are not effectively delivered.

There is Federal, State and Local legistation as well as the enactment of the Mental Health Systems Act, but there still needs to be increased changes and improvement in existing laws to provide the needed mental health services for Black elderly.

From research it has boen discovered that large numbers of older b[illegible]s are unaware of available mental health services.

Older Black people encounter the effects of discrimination based on race, age, low income; which sometimes result in poor physical and mental health.

Research has indicated that Black elderly do not use community mental health services proportional to identi-

fied needs. Studies have shown that only a small percentage of Black elderly receive mental health therapy, although many more may suffer from mental health problems. It has been estimated that from 4% to 5% of community mental health center patients are the elderly of all races and that a smaller percentage of this amount are seen in other mental health clinics and in private practice.

Black elderly, in the minority of the general population as well as in the minority of the elderly population, are in the minority in the mental health system; i.e., in receiving services. There is no correlation between the number of Black elderly who get services and those who need services. For too long, Black elderly have been denied their basic right to good mental health care due to many reasons, among which were/are racism, poverty, inadequate and/or unavailable services, culturally irrelevant mental health programs and lack of knowledge about mental health and mental illness.

There should be concern for the mental health needs of Black elderly and all elderly. The mental health needs of the aging population and especially the Black elderly have largely been ignored with little attention focused on the mental health of this segment of the population. Some attempts have been made to research the problems and to provide needed and appropriate services; but still, Black elderly are infrequently seen in the mental health system; and then, when they become unmanageable in the community.

The older Black population who struggled to build this country, maintain their families, and contribute to

society, having faced discrimination based on racism, poverty and in some cases sexism, have now to contend with some of the same problems as well as with ageism. In addition, many of these seniors may have a variety of psycho-social, physical and medical problems compounded by intrapsychic and external environmental and societal stresses which cause emotional and behavioral problems amd impaired functioning in activities of daily living.

The Black elderly are the 65 years and older members of the Black race. They share the same ethnicity - group identity based on customs, values, tradition and culture. They are acknowledged by the larger society as Black seniors. Despite differences within this group, they share a similar cultural, social, historical, geographical and political perspective. Black elderly do differ in physical, medical and mental halth status, functioning in activities of daily living, income, class, education, social status, language, need for services and supports, etc.

According to the 1980 United States Census Report, there were 2.1 million Black elderly in the United States which make up 8.2% of the older population of 25, 892,000 persons 65 years of age and over; and 7.8% of the Black population of 26,488, 218. Blacks now represent 11.7% of the total population of 226.5 million.

In the community mental health system as well as in the general health care system, there has been a lack of knowledge about the Blacks' culture, values, traditions, and health needs, in addition to the abuses in medical practice - i.e., abuse of patients' rights - right to quality health care.

Individual and institutional racism in health

care has affected Black elderly's access to and acceptance of and receipt of quality mental health care. According to Dr. Robert Butler in Aging and Mental Health "racial prejudice and discrimination affect both the quality and the amount of mental health care available to Black older persons."

What has been done in the past, what can be done in the present, and what will be done in the future to correct the imbalance and injustice in the mental health care system's treatment of Black elderly? The community mental health clinic was and is offered as one solution to the problem.

In the mid and latter 1970's special programs geared to the mental health needs of the elderly were started with attempts to reach those elderly with mental health problems, as well as the high risk elderly. Included among this group were minority elderly. Programs were established in the communities where elderly lived. But the existence of mental health treatment programs in the community where the elderly reside does not mean that the elderly will accept and respond to treatment offered. Therefore, it is most important for community mental health providers to know the people, culture, and community being served, and to have some staff in the programs who are reflective of the population being served. Also, it is important for the community to have an understanding of mental wellness and mental illness, and an awareness of available mental health services.

Many of the Black elderly have been independent and self reliant, and in periods of crises and emotional stresses

have depended upon the informal support of family and friends as well as the Church. To many Black elderly, seeking mental health therapy may be a sign of weakness, denial of religious belief and trust in God, fear of being labeled "crazy", and anxious concern about the value of talking therapy and the revelation of secrets and/or private matters that should not be divulged to outsiders. Also, because of the Black elderly's past history and current life situation in dealing with racism, low income, ageism, losses, distrust of mental health professionals and the many concomitant problems, mental health therapy is not actively sought.

The application of the holistic approach to the individual patient, use of the psychosocial medical model, the offer of traditional and non traditional alternative treatment modalities, the provision of comprehensive services, strengthening of the informal supportive network, referral to other appropriate community social and health agencies, and advocacy for the rights of elderly, can help Black elderly with mental health problems derived from many causes.

The Church continues to play a very important function in the lives of Black elderly. Besides the religious role, the Church has been and continues to be a stabilizing force providing prestige, power and recognition to those elderly who are active in the Church, providing food, clothing and money when needed on occasion, and also providing pastoral counseling for those people in distress.

When the Church can no longer provide the supportive therapy, when the family support network changes and is no longer available for the Black elderly, and when the emotional ties to friends no longer exist, community mental health can

be beneficial to maintain one's mental health, treat mental illness and prevent further pathology.

Black elderly have survived the many medical, mental and social problems faced in their lifetime. Many have exhibited wisdom, strength, determination, patience, pride, endurance and the belief that God will help them in their struggles. They have sometimes been evasive and disguised their feelings which have helped them to cope in the past and may still be used at present, depending on the relationship between therapist and patient.

Before an accurate diagnosis can be made in mental health, the Black elderly's pattern of ego defenses, his emotional development and the environmental and societal stresses impacting upon him must be considered, along with the behavior manifested.

Therapist and patient have feelings about each other, and the transference and countertransference must be dealth with and considered in therapy, and racial factors, when appropriate, must be acknowledged and considered in therapy.

Recommendations

Removal of financial barriers to mental health care
Choice in clinicians if dissatisfied
Research and analysis on the coping skills of Black elderly
Research on the extended family
Alcohol and drug abuse programs for the elderly
Investigation on non compliance in treatment
More Black mental health practitioners especially psychiatrists.
Innovative alternative treatment therapies
Extensive outreach to the elderly in the community.
Home visits
Consultation and education for the community
One stop comprehensive medical, mental and social health care center for integrative services.