Mental Healthcare For Rural Seniors

An Outreach Program in Cedar Rapids, IA, Uses An Integrated Approach to Break Down Barriers to Care

BY MARIANNE SMITH, RN, & KATHLEEN C. BUCKWALTER, RN, PhD

Ms. Smith (not pictured) *is geropsychiatric clinical nurse specialist and training coordinator, and Dr. Buckwalter is geriatric mental health consultant, Abbe Center for Community Mental Health, Cedar Rapids, IA.*

Many elderly Americans, especially those living in rural areas, do not receive needed mental healthcare services because several barriers prevent them from doing so. In the Cedar Rapids, IA, area the Abbe Center for Community Mental Health is attempting to eliminate these barriers.

The Elderly Outreach Project (EOP) was introduced in 1986 to provide mental health services to the rural elderly in a two-county catchment area in southeast Iowa. The project uses a multidisciplinary team (psychiatrist, nurse, and social worker) to assess and treat homebound clients, and it integrates a variety of healthcare, mental health, and human service agencies in planning and delivering mental health services.[1]

Background

The EOP was implemented with the assistance of three-year grants from the National Institute of Mental Health (NIMH) and the Administration on Aging and support from the Iowa State Department of Human Services Division of Mental Health, Mental Retardation and Developmental Disabilities. After staff at the Abbe Center for Community Mental Health identified a need for alternative services to reach the elderly, it developed the program in collaboration with the Heritage Area Agency on Aging.

Staff recognized that older clients were not coming to the center for assistance with mental health problems. Our mental health center, like many others across the country (particularly in rural areas),[2] was serving only a small number of persons over age 65. Despite the fact that elderly persons make up more than 12 percent of the population, they account for only 4 percent to 6 percent of the caseload of community mental health centers (CMHCs) nationally and less than 2 percent of the caseload of private psychiatrists.[3] And a community service survey found that 15

Summary Several barriers prevent elderly persons, especially those living in rural areas, from receiving mental health services. The Abbe Center for Community Mental Health is breaking down some of these barriers in the Cedar Rapids, IA, area.

The center's Elderly Outreach Project identifies and provides mental health services to the area's rural elderly. A multidisciplinary team (psychiatrist, nurse, and social worker) assesses and treats homebound clients.

Four major barriers prevent seniors from using traditional mental healthcare services:

- *A lack of trained professionals.* Because many professionals have not received training in geriatrics, those working with elderly clients should be encouraged to attend educational conferences to fill gaps in their knowledge.
- *Organizational barriers.* Transportation and cost may prohibit elderly persons from seeking mental healthcare. Facilities must revise policies detrimental to clients' well-being.
- *Ageism.* Many elderly persons have internalized negative and incorrect beliefs about what aging is or should be. Education about "normal" aging is essential.
- *Stigma.* The stigma of mental illness is particularly troublesome. Services such as in-home counseling allow clients to get the help they need while keeping their mental illness confidential.

To eliminate the barriers to mental healthcare, increased financial resources are necessary to develop, implement, and maintain innovative programs that can reach frail, isolated, hard-to-find persons in need of mental health, medical, and social services.

percent to 25 percent of seniors in our catchment area were in need of mental health services. However, persons over 65 made up only 1.2 percent of the center's caseload, suggesting a tremendous gap between those in need of and those actually receiving mental health services.

The problems in our community paralleled those identified in a 1978 report of the panel on rural mental health (part of the President's Commission on Mental Health). During the past 15 years, little, if any, progress has been made in addressing the mental health needs of the rural elderly. The panel highlighted some of the problems in rural America:

> Rural communities tend to be characterized by higher than average rates of psychiatric disorders, particularly depression, by severe intergenerational conflicts, by an exodus of individuals who might serve as effective role models for coping, by an acceptance of fatalistic attitudes and minimal subscription to the idea that change is possible.[4]

Unlike many rural communities, in the center's service area, mental health services were available in 1986, when the EOP began. In fact, the Abbe Center offered a wide range of outpatient services, including an outreach clinic in the most isolated area. However, seniors in our community did not seek mental health assistance and therefore did not use the available services. This meant many elderly, suffering from depression, dementia, adjustment disorders, care giver stress, late-onset schizophrenia, and other maladies, went without help. Admission patterns at local and state hospitals suggested that older adults looked for assistance only at the point of crisis. Unfortunately, this pattern often resulted in needless suffering and premature (and in some cases inappropriate) institutionalization—institutionalization that may have been prevented had these persons sought mental health services earlier.

Before implementing the EOP, staff at the Abbe Center had to learn why elderly persons waited until they reached a crisis before seeking mental health assistance. They uncovered a number of barriers that prevented the rural elderly from asking for assistance—barriers that had to be surmounted if the EOP was to be successful.

This article presents the most common barriers to mental healthcare faced by the rural elderly and highlights examples and solutions from the EOP's caseload. In addition, it sets forth strategies for overcoming these barriers and discusses the resultant policy implications.

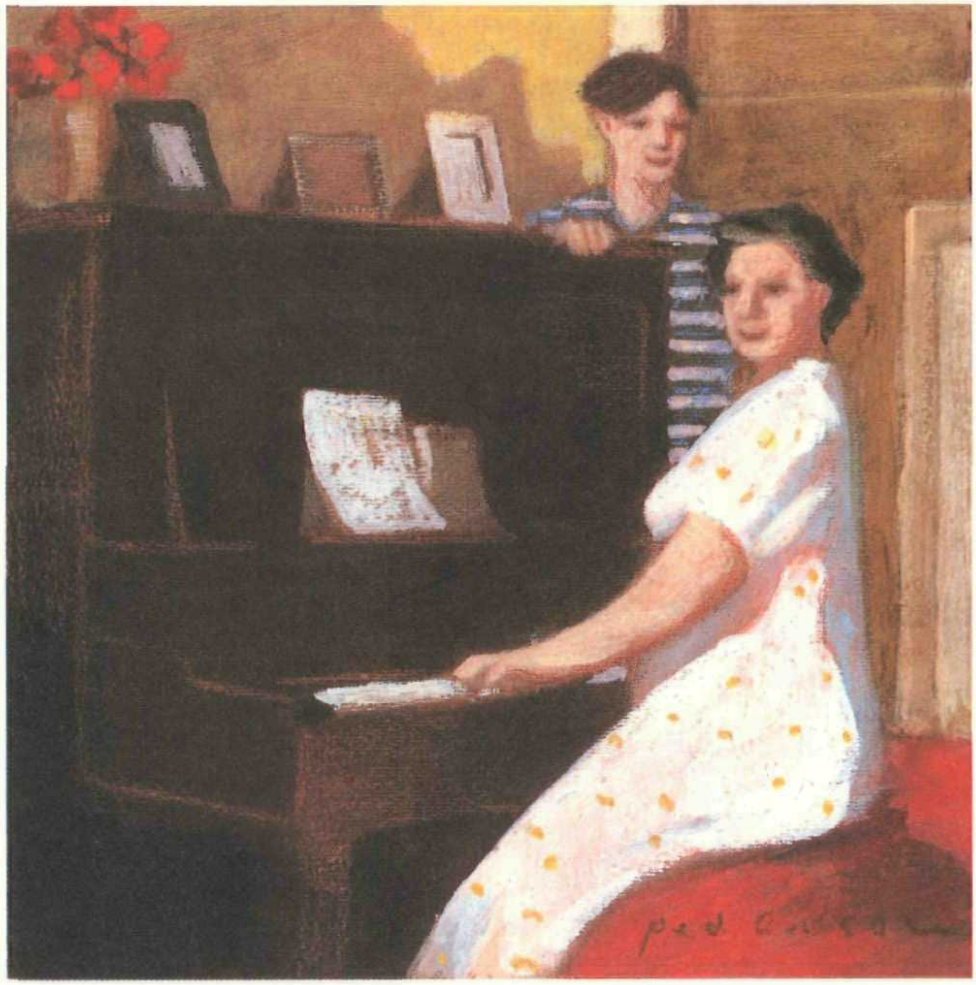
Barriers to Care

A review of the literature[5] and the experiences of EOP's staff during the past six years revealed four major barriers that prevent seniors from seeking mental health services in a psychiatric clinic or mental health center:

- A lack of trained professionals
- Organizational barriers
- Ageism
- Stigma

A Lack of Trained Professionals Many healthcare professionals are not motivated to work with seniors,

Many rural elderly fear institutionalization and wish to continue living independently in the community.



Judy Pedersen

whom they regard as "hopeless cases." And other professionals lack the skills and training necessary to work with this population. Many educational programs preparing mental health professionals fail to adequately discuss late life developmental tasks or problems associated with advanced age, let alone emphasize therapies that are particularly useful with aging clients.

The cost of the service can be prohibitive to those on a fixed income.

When the EOP was launched, members of the multidisciplinary team had varying educational backgrounds and levels of expertise. Some staff had received advanced education in mental health, others had advanced training in geriatrics and gerontology. Only the project director had expertise in mental health treatment *and* geriatrics.

Through joint case review and treatment planning, staff overcame their limitations. This format encouraged the sharing of knowledge between disciplines, which maximized the potential for comprehensive assessment, accurate diagnosis, and effective treatment and referral. In addition, EOP team members attended educational conferences to fill in the gaps in their knowledge.

Organizational Barriers The problems of distance, time, and expense to reach available services are impediments to many rural residents, particularly the elderly who may not be able to drive because of visual impairments. In addition, the cost of the service can be prohibitive to those on a fixed income.

"Mabel," an 83-year-old widow living alone, became severely depressed, delusional, and anorexic after the death of her husband. Mabel's visiting nurse called the Abbe Center for Community Mental Health (before initiation of the EOP) and asked for help. The "intake process" meant Mabel would need to come to the center, be interviewed by an intake technician, and then be seen by mental health professionals who would later develop a treatment plan. Confronted with these seemingly overwhelming requirements, Mabel refused assessment and treatment. The nurse queried, "Couldn't someone from the center see Mabel in her home? Couldn't they bend the rules in this special case?" The center's answer was, "No. If we do it for one, we'll have to do it for all, and we just don't have the time or resources to provide in-home assessment."

"Marie" faced another type of organizational barrier. She refused to sign a release form that allowed the center to bill her insurance for services, which she regarded as charity. Marie appreciated the social worker's assistance and did not want to terminate services, but she was adamant that she could "pay her own way." Before implementation of the EOP, the center's policy was to charge full fees when individuals refused to use the insurance available to them. This meant that Marie would have to pay $74 an hour—a fee she could not afford.

The EOP staff realized they had to examine and revise policies that barred persons from needed services. For example, after initiation of the EOP, a geropsychiatric nurse was able to see Mabel in her own home without all the "necessary" paperwork. Marie was able to continue receiving care and was assessed a fee based on a sliding scale, which enabled her to pay her own way. The Abbe Center's former policy in both these cases had been detrimental to the clients' well-being and impeded the delivery of needed services.

Ageism Americans hold some negative and incorrect beliefs about what aging is or should be. Many elderly persons have internalized these beliefs to some degree. They may think they are incapable of change or unworthy of assistance, or they may believe it is natural to be "old and sad" or that memory loss and confusion are inevitable consequences of the aging process.

"Elsie," an 87-year-old nursing home resident, was labeled "chronically confused" by the staff. Her physician explained to the family that it was "senility" caused by her advanced years. The EOP team urged the family to seek a comprehensive medical workup to rule out other causes of the confusion. Assessment at a nearby geriatric clinic revealed Elsie had a thyroid dysfunction that was responsible for her cognitive symptoms. Her mental status cleared considerably with the needed medication. The confusion was not entirely reversed, however, because the problem had gone undetected and untreated for so long.

Education about normal aging is needed for care givers, the elderly, and their family and friends. Negative attitudes and myths about aging

are still pervasive and must be confronted in multiple ways—through the media's treatment of older adults, educational programs for children and youth, informational materials for families and seniors, and education of healthcare and social service professionals.

In addition, further research about normal, healthy elderly is needed to differentiate between those changes which are associated with aging and those which are the result of disease. Seniors and their families need encouragement to pursue accurate diagnosis and treatment of both physical and mental health problems.

Educational institutions must continue to address the needs of the elderly—in both their formal degree programs and continuing education efforts. Also, the federal government should expand funding for statewide and regional geriatric education centers, especially those serving rural areas.

Stigma The stigma of mental illness is particularly troublesome in rural areas, especially among the elderly, and may take many forms. The **Box** below suggests strategies for eliminating this stig-

ELIMINATING THE STIGMA OF MENTAL ILLNESS

Many factors perpetuate the stigma associated with mental illness. Change is possible, but time, energy, and resources are needed to reverse long-standing patterns of thinking. Some effective strategies to combat the stigma of mental illness can help.

Mental Illness Education

Educational programs and factual information need to be provided to all members of the community (e.g., physicians, social service providers, laypersons, and schoolchildren). Many educational materials are currently available. The Depression/Awareness, Recognition, Treatment (DART) brochures or the "Plain Talk" series, available through the NIMH, provide easy-to-understand explanations of mental and emotional problems. These educational materials need to be placed in accessible, low-threat locations such as senior citizen centers and congregate housing and meal sites—where anyone can comfortably pick them up and read them—not just in mental health centers.

All media must convey the message that many mental illnesses are treatable but some are resistant to treatment—just like physical illnesses. We also need to reinforce the notion that "most criminals aren't mentally ill" and "most mentally ill persons aren't criminals."

Mental health professionals can get this message out by writing articles for newspapers and senior citizen publications. Television and radio stations welcome mental health professionals to do public service announcements, especially during mental health month.

Mental Health Education

In addition to mental *illness* education, we need to promote mental *health* education, particularly for seniors. Many of the stresses that contribute to the onset of mental illness in later life are predictable. Poor health, isolation, and the loss of social support are closely linked to the occurrence of mental illness in the elderly. By receiving education about how to plan for declines that may accompany aging and how to use existing community resources and services, many elderly and their families could be spared needless suffering. By demystifying mental health and talking about it in commonsense terms, we can increase the likelihood that young and old alike will ask for assistance when needed.

Relabeling Resources

We sometimes overcome barriers by using different words. We named our service "Elderly Outreach Project" rather than the "Mental Health of the Rural Elderly Outreach Project" to avoid the stigma. During EOP's first year of operation, the team set up a "mental health screening" station at the local senior center's health fair. Only four people approached the table for information. The next year, the same table was relabeled "Adjusting to the Later Years." It was overrun with business.

Members of the EOP team describe their job in terms of their core discipline (e.g., "My name is Marianne and I'm a nurse") and avoid using terms like "psychiatric" or "mental health." When team members introduce the idea of therapy, they typically refer to it as "talking it out." Also, the term "counseling" is less threatening than "psychotherapy." Minor changes in the selection of words and explanations often reduce the threat and stigma associated with mental illness and allow older persons to accept needed help more comfortably.

Innovative Services

Healthcare providers must critically examine the types of services provided to the elderly and whether they meet their needs. The stigma associated with mental healthcare will not disappear soon. We need to provide services that overcome both physical and psychological barriers.

To achieve this, healthcare providers can:

- Take services to elderly clients (provide in-home services)
- Educate empathic community members to act as gatekeepers, identifying people whose behavior and appearance suggest they need help
- Develop transportation systems that encourage people to leave their home without the neighbors knowing where they are going
- Use low-threat approaches to increase the likelihood of acceptance
- Work as a group, collaboratively, using a multidisciplinary model and networking extensively with other community agencies

ma. Many older people are afraid neighbors and friends will find out about their "mental problem" and make them the subject of gossip and the brunt of bad jokes. They also fear being avoided, shunned, or ostracized. Their fears are not always unfounded.

Many Americans believe mental illness is untreatable and irreversible. They view depression as an everyday occurrence that persons should be able to handle on their own. The words "senile" or "demented" strike fear in the hearts of many, especially the elderly. In some cases Alzheimer's disease has elicited a paranoid reaction: People stay away—not understanding, fearing the strange behaviors, and believing they might "catch it."

"Henry," a retired school principal, was referred to the EOP after a stroke left him partially paralyzed and extremely depressed. He welcomed the staff's home visits and was receptive to psychotherapy. Because he was able to drive, the EOP team nurse asked Henry if he would come to Abbe Center to see her. Henry considered the request, but concluded: "I can't. I can't walk through those doors. I drove by your center and tried to imagine going in, but I just can't bear the thought of someone seeing me. They'd think I was nuts." The nurse therefore continued to visit Henry at home.

Many persons continue to believe they will be abandoned or "locked up" if they accept any type of assistance for a mental problem, even though psychotropic medication has virtually eliminated long-term institutionalization as a treatment for mental illness. Many rural elderly value open space and independence and fear institutionalization as a fate worse than death.

Although the focus of the EOP's work is to *prevent* premature institutionalization, many seniors respond to our offer of services by saying, "You're not going to put me away!" or "I don't need any nursing home!" Their suspicions are so strong that we must continually reinforce the idea that we support their wishes to live independently in the community and want to help them achieve that goal. For example, we refer them to additional community-based services such as home-delivered meals and visiting nurses.

Another barrier to care is some persons' belief that they should be able to "handle problems themselves." They view mental health assistance as a sign of personal weakness or even defeat. These attitudes may prevent people from getting needed assistance. In spite of their failing health, limited incomes, and obvious mental distress (depression being the most common), many elderly persons initially resist help of any type. Typically, three or four visits by an EOP team member are needed to achieve a comfort level that permits even the simplest interventions.

"Charles," a farmer in his early sixties, became severely depressed. He fought the depression, saying that he "should be able to shake it." But the depression worsened. Charles eventually turned his hop operation over to his son. He became more and more despondent and even contemplated suicide. With encouragement from his family, he finally saw an EOP psychiatrist who prescribed medication that alleviated his depression. At first the psychiatrist visited Charles at home; eventually Charles went to the mental health center. Charles sheepishly revealed how afraid he was the first time he walked into the mental health center. "I know I shouldn't feel this way," he said. "I know depression is an illness and I shouldn't be ashamed. But I am. If the fellas at the elevator ever heard that I saw a 'shrink,' I'd never hear the end of it! I just don't think that I could live with it." To alleviate Charles's anxiety, the psychiatrist emphasized that depression has a biological basis. It is an illness, just as diabetes is an illness, and both require medication.

Policy Implications To eliminate the barriers to mental healthcare, increased financial resources are necessary—resources to develop and implement innovative programs like the EOP, which can reach frail, isolated, hard-to-find persons in need of mental health, medical, and social services. Federal, state, and local policymakers should consider the following:

- Federal policy is needed to build and maintain mental health programs in rural America.
- Federal and state dollars need to be redirected from custodial care to home care and rehabilitation of the elderly.
- Medicare and Medicaid reimbursement guidelines require reform to include mental health treatment with multiple services.
- Local, state, and federal representatives from aging service networks and mental health providers must provide and support collaborative programs.
- These same representatives must advocate for regulation amendments to accommodate untraditional and innovative service delivery systems.
- Greater communication and cooperation among all levels of government, advocacy groups, and providers must occur to accomplish a comprehensive care system for the rural elderly.

Success Despite No Funding

On the basis of a three-year evaluation (1986-89), we found that the EOP is a cost-effective service delivery system preventing institutionalization of a significant number of rural elderly.[6] EOP services cost $622 a patient for a year. We

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familial traditions. Care for the dying is impoverished if the patient's cultural context and resources are ignored and he or she is treated as simply a technical problem.

Catholic healthcare institutions today are challenged to respect the diversity of the social and religious values of those who work at and are cared for in the institutions. Healthcare professionals will need courage and humility to affirm their own faith while respecting the diversity around them. Catholic healthcare institutions must strive to promote a sensitivity and respect for cultural diversity as they respond to the needs of the dying and those who care for them.

Sensitivity begins by welcoming the expression of cultural diversity and by promising to respect differences. When cultural differences clash with moral convictions and reconciliation seems impossible, the parties in conflict should disengage with as little disruption as possible. But no one should ever be asked to violate deeply held moral convictions.

VALUING EVERY STAGE OF LIFE

Catholic healthcare institutions should implement policies, educational programs, mission effectiveness committees, and ethics committees to respond to the multicultural dimensions of the care of the dying. As the assisted-suicide and euthanasia movement gains strength, Catholic healthcare providers need to pay attention to how cultural factors influence attitudes about care for the dying in order to fashion responses that will not only prompt them to provide compassionate care, but also give clear Catholic witness to the dignity and value of the person at every stage of life. □

EUTHANASIA

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euthanasia—which otherwise would be unacceptable to them and to society.[12]

I agree with the cardinal. The reasoned and sophisticated arguments against the legalization of euthanasia will never be heard and the real discussion will not take place unless, as individuals and providers of healthcare, we first meet this critical challenge. □

NOTES

1. Joseph Bernardin, "Address: Consistent Ethic of Life Conference," *Consistent Ethic of Life*, Sheed & Ward, Kansas City, MO, 1988, pp. 86-95.
2. Joseph Bernardin, "Euthanasia: Ethical and Legal Challenges," *Origins*, June 9, 1988, p. 52.
3. Arthur J. Dyck, "An Alternative to the Ethics of Euthanasia," as cited in Richard M. Gula, *What Are They Saying about Euthanasia?* Paulist Press, Mahwah, NJ, 1986, p. 169. These reflections are deeply indebted to Fr. Gula's masterful analysis of this important subject.
4. Gula, p. 70.
5. Courtney S. Campbell, "Religious Ethics and Active Euthanasia in a Pluralistic Society," *Kennedy Institute of Ethics Journal*, vol. 2, 1992, pp. 253-284.
6. Edward Shils, "The Sanctity of Life," in Daniel H. Labby, ed., *Life or Death: Ethics and Options*, University of Washington Press, Seattle, 1968, p. 12.
7. Gula, p. 97.
8. Gula, p. 70.
9. Gula, p. 71.
10. Ron Hamel and Edwin DuBose, "Views of Major Faith Traditions," in Ron Hamel, ed., *Active Euthanasia, Religion and the Public Debate*, Park Ridge Center, Chicago, 1991.
11. Robert N. Bellah, *Habits of the Heart: Individualism and Commitment in American Life*, HarperCollins, New York City, 1986.
12. Bernardin, "Euthanasia," p. 56.

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found this to be substantially lower than costs reported by a group of area mental healthcare providers. Yet, in spite of its success, no local, state, or federal funding bodies offered support of the project after the grant period. Elderly Services (formerly the EOP) is now a permanent part of the Abbe Center for Community Mental Health. It has continued only because of the center's commitment to services for the elderly and its diversion of profits from other programs to support the program.

The EOP is not the first successful and innovative service to experience this difficulty. However, our experience reinforces the need for state and federal planners to reexamine existing policies and to review methods to fund and sustain successful service delivery programs, especially those serving the rural elderly. □

NOTES

1. For a description and evaluation of the Elderly Outreach Project, see Kathleen C. Buckwalter et al., "Mental Health Services of the Rural Elderly Outreach Program," *Gerontologist*, March 1991, pp. 408-412.
2. J. A. Krout, *The Aged in Rural America*, Greenwood Press, Westport, CT, 1986.
3. M. D. Kermis, "Equity and Policy Issues in Mental Health Care of the Elderly: Dilemmas, Deinstitutionalization, and DRG's," *Journal of Applied Gerontology*, September 1987, pp. 268-283.
4. President's Commission on Mental Health, *Task Panel on Rural Mental Health*, vol. 3, appendix, U.S. Government Printing Office, Washington, DC, 1978, p. 1,164.
5. R. Raschko, "Systems Integration at the Program Level: Aging and Mental Health," *Gerontologist*, October 1985, pp. 460-463; Kermis; B. D. Lebowitz, E. Light, and F. Bailey, "Mental Health Center Services for the Elderly: The Impact of Coordination with Area Agencies on Aging," *Gerontologist*, December 1987, pp. 699-702.
6. Buckwalter et al.