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LETTERS OF TRANSMITTAL

SEPTEMBER 6, 1961.

To Members of the Special Committee on Aging:

Submitted herewith for the consideration of the members of the Special Committee on Aging is a policy paper on "Mental Illness Among Older Americans," prepared at my request by Mr. Elias S. Cohen, Commissioner of the Office of Aging, Pennsylvania Department of Public Welfare. The committee and the committee staff neither approve nor disapprove of the findings and recommendations of the author. It is being printed and distributed for the use of the committee members and for comment by experts interested in the subject.

PAT MCNAMARA,
Chairman, Special Committee on Aging.

SEPTEMBER 1, 1961.

Hon. PAT MCNAMARA,
Chairman, Special Committee on Aging,
U.S. Senate, Washington, D.C.

DEAR SENATOR MCNAMARA: Transmitted herewith is a study paper prepared by an outside expert, on the problems of mental illness among the aged, written by Mr. Elias S. Cohen, Commissioner of the Office of Aging, Department of Public Welfare, Commonwealth of Pennsylvania. It is presented as prepared by him, for consideration and comment by the committee and staff.

Prior to undertaking his duties with the Pennsylvania Office of Aging, Mr. Cohen served as assistant to the Indiana Commissioner of Mental Health. Mr. Cohen has also worked in Illinois with the Manteno State Hospital (a 8,000 bed mental hospital) and with the Public Aid Commission. In Albany, N.Y., Mr. Cohen held responsible positions with the State Department of Social Welfare.

HAROLD L. SHEPPARD,
Staff Director, Special Committee on Aging.

MENTAL ILLNESS AMONG OLDER AMERICANS

(By Elias S. Cohen)

I. THE NATURE OF THE PROBLEM

Consideration of mental illness and the aged focuses attention upon the No. 1 health problem of this country since it affects the group that presents the No. 1 population and socio-economic problem. To complicate the picture further, gross confusion prevails over what constitutes "mental illness" where the aged are concerned, confusion over the organization of services to deal with the aged showing psychological dysfunction, and confusion concerning legal and fiscal responsibility for the care of such aged. The question is brought up sharply by the plight of the aged in the mental hospitals of the United States.

About one of every three beds in public mental hospitals is occupied by a person 65 or older—approximately 165,000 patients, an increase of 95,000 in the past 20 years.[1]

In 1958 first admission rates for the 65 and over group were two and a third times that of the 25 to 64 group, and almost four times that of the population aged 15 to 24.[2] Twenty-seven percent of all first admissions are 65 and over.[3]

The trend over the past 20 years has indicated an increase of 40 percent in the ratio of persons 65 and over hospitalized for mental illness to the total aged population,[4] while for all other age groups there has been a steady decrease in the ratio.

The aged mentally ill in mental hospitals derive from two main groups: (*a*) those who were admitted at earlier ages and who have grown old in the hospitals; (*b*) those who have been admitted at age 65 and over, 83 percent of whom are diagnosed as having senile and arteriosclerotic brain damage.[5] The resident population is about equally divided between these two main categories of aged persons in the mental hospitals. The growth of the aged resident population of the mental hospitals is all the more startling when we consider that death rates among those admitted to mental hospitals at age 65 and over run in excess of 30 percent within the first year of admission.[6]

CONFUSION IN THE ARRAY OF SERVICES

A recitation of statistics concerning the aged in mental hospitals is only indicative of the broader problem which exists with reference to the aged and mental illness. The plight of the mental hospitals reflects, frequently, the lack of resources in the community for proper placement in the first instance, the lack of resources in the community for maintaining the patient upon discharge, and, in many instances, confusion about what the patient needs or what can best serve his particular problem.

See footnotes, p. 20.

A study in New York State on psychiatric services for the aged found that—

> The incidence of physical, mental, and social disabilities among [aged] persons admitted to [old age homes, nursing homes, and State hospitals] was very high and the differences between [these populations] were not as great as the amount of overlapping in frequency of disorders in the three types of institutions. The degree of difference between the types of institutions was not as great as the differences between different institutions similarly classified. Despite administrative policies favoring the segregation of persons according to physical or mental disabilities, the direct examination of individual aged persons in institutions of presumably selective nature revealed those deficits or disabilities to exist in combinations which *would easily permit reclassification of the individual to one of the other types of protective shelter should there be an administrative or economic circumstance for reclassification.*[7] [Italic supplied.]

Other studies give additional evidence that this is the case. More than half of the patients in nursing homes in the United States have periods of disorientation,[8] and the state of nursing home operation certainly raises the question as to whether these patients, sick in mind as well as in body, receive the care and treatment that modern medicine, and particularly modern psychiatry and neurology, has at its disposal.

Thus, even narrowing consideration to the problem of the aged patient with psychologic dysfunction severe enough to warrant constant supervision in an institutional setting, there is remarkable lack of clarity as to the most appropriate placement for the patient. The executive director of one of the Midwest's excellent sectarian homes advised the committee that, "Little or nothing is known about the people whom we classify as 'senile.' There is no authoritative statement about the meaning of the term, nor is there any information about what best can be done to help those so classified." [9]

If, however, one proceeds further to consider that there are patients in mental hospitals and other institutions who have some behavior problems which require supervision, but may not require 24-hour institutional care, the dilemma of the aged and mental illness is compounded.

CONFUSION IN FISCAL RESPONSIBILITY FOR INDIGENT AGED IN INSTITUTIONS

The lack of clarity in the situation is further illustrated by the matter of fiscal responsibility for the indigent aged person who may have some mental illness. For example, consider an aged patient who is severely disoriented, but who presents no threat of physical harm to his fellow patients, himself, or to the staff who cares for him. He may or may not be infirm, and may or may not be incontinent. He is unable, however, to take part in most of the activities of daily living. He may chatter or sing incessantly, may pick at his wearing apparel and bed clothes, or he may sit vacantly and quietly rock his days away in private silent retreat from the world about him. This patient will be found in equal dispersion among the State mental hospitals, the nonprofit homes for the aged, the private nursing homes and the county infirmaries.

In Pennsylvania, if he is indigent the cost of his care will be borne as follows: in the State hospital, by State revenues alone; in the private nursing home, by State and Federal revenues paid through the public assistance medium; in the nonprofit home for the aged, by State and

Federal revenues paid through the public assistance medium, plus that measure of support which is provided through private philanthropy of religious, community, or other origins; in the county infirmary, by local revenues alone.[10]

This kind of fiscal crazy-quilt pattern results too frequently in the placement of patients on the basis of something other than the patient's overriding need for care. This same lack of clarity makes it possible for each of the institutional settings to deny primary responsibility for the aged patient with mental problems, and to seek his referral or removal to another type of facility, albeit usually on the basis that "the patient cannot benefit from this type of program" or "we are not set up to handle these mental patients".

THE CONSEQUENCES OF REJECTING ATTITUDES

Any survey of mental hospitals, nursing homes, county infirmaries, or other facilities where there are significant numbers of aged persons with psychologic disorders will reveal that this group, as a whole, fares badly. They are given up as hopeless, relegated to back wards euphemistically called "continued treatment" but in actual practice "discontinued treatment" situations, or are segregated in private and nonprofit homes away from the other patients, and certainly where visitors will be least aware of their presence. This group of patients suffers the rejection not only because they are aged and useless in the eyes of our youth-oriented society, but also because they are mentally ill. The Joint Commission on Mental Illness in its monumental final report concludes that while—

> People do feel sorry for them, [the mentally ill] * * * in the balance, they do not feel as sorry as they do relieved to have out of the way persons whose behavior disturbs and offends them * * *. Rejection, as practiced against the psychotic patient, takes many forms, some tantamount to complete denial of his right to human existence.[11]
>
> With the growth of urbanization, the care of the mentally ill took the form of removing social rejects through a disposal system isolating them well beyond the city limits in large "asylums" functioning as human dumps.[12]

This overlay of rejection has made it difficult even for the professionals working in the field to appreciate and plan with respect to the close interrelationship of the psychiatric factors to the social, economic, and physical health problems which face the aged.

The Consultant on Aging to the New York City Department of Welfare pointed out to the committee that the day care center program in New York City maintains some 250 persons in the community instead of in mental hospitals because of the social service provided the persons who attend.[13]

Receiving psychopathic wards in hospitals everywhere reveal scores of patients who arrive with all sorts of behavioral symptoms and disorientation which are disabling, the etiology of which lies in simple malnutrition, which in turn may be the result of poor personal economic resources.

Emotional reaction to serious physical illness is not uncommon among the aged, and yet too little attention is devoted to the emotional components of physical illness which may call for some supports during convalescence if emotional crippling is to be avoided.

The reasons for institutionalizing the aged are manifold and complex, and the presence of behavioral symptoms demands careful evaluation if proper programing is to be prescribed for the individual.

THE INSULAR NATURE OF MENTAL HOSPITAL PROGRAMS

The special problems presented by the mental hospital admission, retention, and discharge process deserves still further analysis. Admission for inpatient care in a mental hospital depends upon a number of factors: the nature of the illness, the services available to prevent hospitalization, the services required for restoration to the community, and the services in the community necessary to facilitate discharge. The process of admitting an aged person to a mental hospital depends upon a series of decisions which take place in the community, in the family, and in agencies. These decisions are seldom reached in concert with the in-patient facility. By the time admission or commitment is to take place, the in-patient facility is faced with a narrow problem: to accept the patient, or to reject him after the various forces have decided that mental hospitalization is the appropriate answer. In other words, the degree of control is a narrow one for the hospital—the basic decisions are made outside the area of its control.

The mental hospitals' traditional isolation from the process of community social services puts them at the mercy of the force of the community's pressure to cast off its aged social rejects. This has major implications around the organization of services for the aged suffering from mental illness. There is a need for not merely understanding, but for developing an entirely new series of relationships between the mental health programs currently in existence and the variety of social welfare programs which have come into being during the past 30 years.[14] For the most part, these services have been developed without reference to the mental health programs, with the net result that in instances where mental illness may be detected early, there is no machinery for easy referral, or for the purchase of psychiatric care. In the public assistance programs, there are relatively few States which make available funds or staff to secure psychiatric diagnosis and care, even when such may be clearly indicated by the condition and behavior of a recipient.

Any consideration of the nature of the problem must take into account the further complicating factor of lack of definition and purpose in many community-based programs which has a close relationship to the question of maintaining aged persons in the community in lieu of mental hospital or other institutionalization. Even the mental hygiene clinic has proceeded outside a clear frame of reference to mental hospitalization. Intake in many such clinics is heavily weighted with those who represent a wide variety of neurotic problems, but who may not be so disturbed in their functioning that service is an absolute requirement. This is not to deprecate the alleviation of psychic pain. It is rather that such weighting acts to make less service available to those who are the mental hospital's potential customers.

Too few of the community clinics have taken on the clear responsibility for the followup of patients discharged or released from mental hospitals. To the extent that this is so, the mental hospital is obliged to let the ex-patient make his way the best he can, or it must set up a competing clinic service which tends to increase the isolation from the traditional configuration of community programs which could be of service.

Too few community-based programs have developed clear criteria or definition of the problems they are designed to solve, and as a consequence they encounter considerable difficulty in measuring effectiveness of the job they actually do. This is a commentary, too, on the failure to diagnose precisely the social problem which may be present or to prognosticate its course and set up the probable gamut of social programs that will be required for solution.

This, by no means, denies the interest that appears to exist in the development of services. To the contrary, the report of the Joint Commission on Mental Illness points out—

> There is * * * a real eagerness on the part of citizens and professional workers throughout the country to take action with respect to improving services in support of mental health * * *. There is a ready acceptance of the role of the supportive services [such as schools, churches, public health, and social service agencies] and a recognition of the potentialities in the total mental health program.[15]

However, it goes on to say that—

> There is a great deal of confusion in regard to what kind of supportive mental health services communities should be developing.[16]

The joint commission has found "distressing" the

> * * * widespread lack of understanding of how to launch and carry on mental health programs at every level from the national scene down to the smallest hamlet. Efforts to formulate mental health programs are too often haphazard and uncoordinated, well-intentioned but amateurish and without professional guidance.[17]

It is readily apparent that while the problems of the aged and mental illness have their unique attributes that set them apart and make them the proper object of study, they are inextricably a part of the overall problems facing those who seek to serve the mentally ill. While the major influx of aged persons into the mental hospitals complicates the mental hospital program, it serves to bring into clear focus the problems which have been part and parcel of the mental health picture for years—the failure to organize community programs with clear objectives of aiding the solution to improper mental hospital utilization, and secondly, the self-imposed isolation of mental hospitals and mental health programs from the community and related services that have a major contribution to make.

One of the major contributions to be made at the Federal level of government is the reexamination of the several grant programs in the health and welfare field with the view to developing better integrated programs at the State and local operating levels. Present grant programs are alined along service lines without reference to the solution of multiple problems which beset the recipients of services in the health and welfare fields. Yet, study after study has shown that a relatively small group of the population receives the bulk of health and welfare services. Despite these findings, the organization of services continues to proceed on the assumption that trouble appears in families and social units only in terms of one problem at a time.

SPECIAL POPULATION FACTORS

Finally, in considering the nature of the problems in organizing services to deal with the aged and mental illness, one must consider certain basic characteristics about the population, which may provide some clues with reference to organization of services.

A very small proportion of the aged live in institutions—about 3 percent of all those 65 and over. However, as noted above, the rate of first admissions of the 65 and over group to mental hospitals is high.

Income of the aged is typically low, and most aged receive social security benefits—about three out of every four aged persons (62 and over) in 1961 are receiving OASDI benefits.

The aged use about two to two-and-a-half times as much hospital care in terms of average stays as those under 65.

For the very old, a large proportion—one-third—of those 80 and over rely on public assistance for their maintenance.

These familiar statistics are cited here once again to suggest that a majority of the aged have as a point of common contact certain agencies whose function until now has been related to the provision of income, with little emphasis on the provision of service and diagnosis. While it is true that the 1956 amendments to the Social Security Act provided for reimbursement to the States of part of the expenditures for service given to recipients or applicants for public assistance, the fact of the matter is that few States have had sufficient resources to implement what the amendments intended.

The program which carries the major burden of income maintenance and which is a source of contact for the majority of older persons in this country—the old-age and survivors insurance program—is still completely oriented to the payment of insurance benefits and incorporates no services in its program.

Even the comparative extensive use of hospitals and other medical care facilities by the aged has not produced changes in general hospital programs which might conceivably affect admission rates of older persons to mental hospitals.

Thus, careful study of the aged population, the points of common contact which it has with services that might be organized to deal with diagnosis and identification of functional disability appears indicated.

II. MAJOR PROBLEMS AND SHORTAGES CONCERNING MENTAL ILLNESS AND THE AGED

The gaps and problems in our mental health programs which affect the aged may be viewed in various ways. Central to the problem of the dilemma of mental hospitals is the matter of control over admission and discharge of aged persons. This is bound up in the organization of a wide variety of resources in the community. The Joint Commission on Mental Illness cites the report on community resources in mental health as examining "what resources for mental health we have in the United States over and beyond those provided by psychiatry and other mental health professions whose work is centered in medical institutions." [18] The report goes on to describe briefly the relationship of public health programs, public welfare, child welfare, court services, public schools, recreation, churches and family service agencies to the mental health programs.

It then puts the hard question to the community clinics, "How, then, does the mental health clinic fit into the picture of community resources?" The clinics must concentrate on providing psychiatric treatment for acute mental health cases and for patients who can be helped either short of admission to a mental hospital or following discharge.[19]

In discussing community planning for such services the Commission makes four points:

(1) Community mental health programs must be shaped around local needs.

(2) The States must take strong initiative to provide consultation in depth for local community planning.

(3) There must be massive expansion of available manpower pools in the promotional and supportive agency programs.

(4) Broad research is necessary around the epidemiology of mental illness, and experimentation to be made possible for controlled trials in supplying additional services to fill out gaps in the total mental health resources constellation.

Major change, however, is suggested in the organization of services in the community for the mentally ill. First, the report concludes that it is—

> * * * inescapable that during the foreseeable future treatment is destined to become more horizontal and less vertical in scope. We cannot blink away the fact that it is being undertaken in some fashion or another by teachers, probation officers, public health nurses, sheriffs, judges, public welfare workers, scoutmasters, clergymen and many others * * *. Every effort must be made, then to provide nonpsychiatrically trained personnel in many fields with as much additional knowledge as possible. They are treating the mentally and emotionally disturbed and will continue to do so.

The second point the report makes in this vein is this:

> The initiation for the creation and development and coordination of mental health resources in communities rests foursquare with mental health leaders * * * in the process of helping to develop these resources, they will have to recognize and learn to live with their reliance on many other individuals who, by the force

of circumstances, are involved in the treatment of mental and emotional disturbances.[20]

As central as the organization of mental health services is to the problem, it nevertheless remains important to review five major gaps in programing for mental illness and the aged. They are as follows:

(1) A major lack of various services designed to help individuals in the community;

(2) A major lack of services at the hospital;

(3) A major lack of finances and financial ability on the part of the States;

(4) A major lack of manpower in the professions essential to the services for the aged and the mentally ill;

(5) Lack of direction in research efforts.

LACK OF VARIOUS SERVICES DESIGNED TO HELP INDIVIDUALS STAY IN THE COMMUNITY

That there are inadequate services to recognize and treat in the community the aged who have mental and emotional disturbances, is nothing short of amazing in view of the general recognition by experts in the field of mental health of what can and should be done. Dr. Daniel Blain, commissioner of mental hygiene for California testified before the committee that as long ago as 1949 the California Department of Mental Hygiene faced the problem of a major influx of aged patients, and that "although these individuals needed attention, it was felt then, as it is now, that a mental hospital was not the place for them." He cited a study at Napa State Hospital that indicated that—

> * * * of 100 newly admitted male patients 65 and over, only 59 percent were admitted because of obvious psychotic symptoms * * *. It would appear that for the most part, although there was need for some treatment of these patients, in many cases they could have been treated better and more effectively in their own communities and in some cases in their homes.
>
> Unless a person is suffering from a mental illness requiring care and treatment in a State mental hospital, regardless of age, that individual is better off when treated in his own community, close to his relatives and friends and in an environment which has helped to mold his entire life and to which he would naturally find it easier to adjust. This means that the responsibility for the care of the individual should rest with the family and where this is not possible or practical with the community.[21]

A similar view was expressed by Dr. Regis F. Downey, superintendent of the 3,000 bed Mayview State Hospital in Mayview, Pa. He pointed out that the 504 persons over 65 admitted in 1957 and 1958 ran the diagnostic gamut—

> from the old person without a home to the mildly confused individuals without interested friends and relatives, and those persons whose major problem was serious physical illness, to the frank psychotic. Of the total number admitted there was a relatively small percentage who could be declared insane if the term "insanity" was applied in the strict sense. Of the total number it was possible to return less than 10 percent to the community. A clinical estimate indicates that 40 to 60 percent did not require hospitalization in a public psychiatric hospital 3 weeks after their admission.
>
> Our experience indicates that many would not have required admission had there been instituted measures to correct physical ailments such as malnutrition, diabetes, hypertension, and cardiac decompensation.[22]

Other witnesses and correspondents testified in the same vein, and it is doubtful if any competent authorities could be found who would not agree with Drs. Blain and Downey.

COMMUNITY EVALUATION CENTERS AND CLINICS

There is an immediate need for community evaluation centers organized on a much broader base than the traditional psychopathic receiving service. The single problem of the aged emotionally and mentally disturbed group of persons has made clear that such evaluation centers must include not only evaluation of suitability for mental hospital placement, but must also be prepared to make positive recommendation and arrangement for care and treatment under other auspices when and if this is the best prescription for the patient. Such programs must include, where the aged are concerned, arrangements for physical and nutritional therapy without reference to the mental hospital. There must be an appropriate combination of reception, medical and social diagnosis, placement, where indicated, service in the form of short-term medical and psychiatric treatment, social service counseling, and proper referral, and some relationship to a follow-up of those who come to the attention of the service.

However, to be truly effective, such a service should be utilized not only for those seeking admission to mental hospitals, but for those who seek admission to county infirmaries, or those who may be referred by public welfare agencies for evaluation. Only in this way will the mental hospital and other mental health programs become more closely bound to the constellation of community services.

The range of community services which extend beyond the basic reception and evaluation center function have been indicated by many.

Traditionally, we have looked to the mental health clinic as a major resource, and a major hope. A statistical study by the NIMH Biometrics Branch of clinics operating in 1956 indicated that their distribution was uneven, that they tended to follow concentration of population.

As cited in the Joint Commission report, however, the study indicates that present operation of the clinics may leave much to be desired. More than 20 percent of clinic patients had only one interview and 60 percent had less than five, with the average around three. While the study makes no comment about the extent of services held out to the aged, it has been observed that the aged, in fact, comprise a very small percentage of the clinic load, despite its significance as a factor in mental hospital admissions and rates of residence. It would appear that even where the clinic services have been established in a community, the aged are excluded, either consciously or otherwise. It may be that where the aged are concerned there must be a broadened concept on the type of clinical service which should be available. Some have suggested geriatric all-purpose clinics which would embrace complete physical diagnosis and prescription along with psychiatric therapy and social counseling.

The need for counseling services was cited to the committee in San Francisco where the United Community Fund of that city reported on a study of counseling needs of over 1,000 aged persons. More than a fourth of the problems presented by older people fell in the personal-social category. The study concluded, among other things that "There is not enough counseling service available in San Francisco to meet the needs of this group." [23]

THE RANGE OF SUPPORTIVE SERVICES

If supportive services in the community are ranged in terms of the degree of support they provide we may achieve a better concept of the gamut of service which lies between wholly independent living and mental hospitalization or other institutionalization. Toward the "independent" side of the scale we might find housing in a receptive environment, as for example, the apartment units of Presbyterian Village in Detroit, or York House in Philadelphia. While these are not intended by any means to take on those who might otherwise be candidates for the mental hospital, they do effectively reduce the emotional and physical stress which inadequate housing may place upon older people and which may ultimately lead to pathological conditions bringing about a functional disability.

On the other hand, the Kundig Center program of the Catholic Archdiocese of Detroit is a program of housing, recreation, and food service which has kept scores of people living in the community, in independent housing, but with considerable degree of surveillance. This type of program has taken forgetful, sometimes confused individuals, and others who without support would require institutional care, out of institutions, and has undoubtedly prevented the mental hospitalization of others. There has been far too little experimentation with different types of housing arrangements offering a receptive and supportive environment. While perhaps we cannot hope for a level of community tolerance and acceptance equivalent to the Gheel, Belgium, experience, we should be willing to explore and expand programs which have had success.

The report of the Subcommittee on Problems of the Aged and Aging [24] pointed to homemaker services to relieve the stresses of daily management for some older persons who would otherwise face institutional care. The validity of this program for the aged who may require admission or rehospitalization in a mental hospital was recognized by the community mental health services program of the Pennsylvania Department of Public Welfare which has given support in recent years to the Lackawanna County Family Agency to aid in keeping the elderly out of the State hospitals. However, use of this effective device is sorely limited—in 1958 in 1 sample week only 501 aged persons were being served by homemaker services in the United States.[25]

Closely related to homemaker service is the range of home medical care programs which may provide visiting nurse services designed to aid a family care for someone who is ill and aged, to complete organized home medical care providing the team services of a physician, nurse, social worker, and physical and/or occupational therapist. That such programs have prevented or postponed institutional placement is manifest many times over. Yet organized programs are few and far between. In Pennsylvania, for example, with over 1 million persons in the 65-and-over group, there are 4 programs which serve about 300 people at any one time. The use of home care services is a major item overlooked in the measures to prevent institutionalization.

Moving further on in the range of services designed to prevent mental hospitalization, one must consider services outside of one's own home. The day-care-center program, which has had success in New York City, has already been cited in terms of its significance in

preventing mental hospitalization of the aged. The consultant on aging to the New York City Department of Welfare has claimed major health benefits accruing from the day-center operation—he points to prevention of 250 mental hospital admissions, a drop of from 50 to 75 percent in clinic attendance after 6 months attendance at the clinic, and reductions in the periods of convalescence following hospital discharge. Yet, with this evidence readily at hand, neither health nor recreation agencies, public or private, outside of New York City have moved forward with a massive day-care-center program. There are a scant 200 such centers in the entire Nation.

The availability of day centers might make possible the retention of aged parents in the homes of their working children. Some older persons cannot be left alone all day, without someone to prepare a meal, or remind them to take medicine. For these older people, without a place to go, or without someone to provide this minimum care and attention, institutionalization becomes the only alternative. If the stresses are sufficient, behavior may deteriorate so that the mental hospital receives the patient, who perhaps needed only the attention and program which a day-care center could have provided.

For those who require supervision in a family setting, foster home care or family care offers another community based social service which can relieve many pressures in mental health institutional programs especially where the aged are concerned. While many States have introduced foster care programing in their mental placement systems, notably Maryland, California, and Michigan, foster home care has not received the attention it deserves. No effort to develop adult foster care programs has been evidenced similar to the major focus on foster care for children which was developed as a response to the problems of institutionalization of children. The report section on social services [26] indicated the large numbers of patients in chronic disease facilities who might be returned to the community under foster care programs. A study of patients over 65 living outside the mental hospital but on the mental hospital books, showed that in New York, foster care accounted for 592 or 32 percent of such cases; California, 200 or 18 percent; Michigan, 165 or 38 percent; and New Jersey, 111 or 17 percent. About one-half of the 35 States reporting used foster care to some extent for placement of older patients.[27]

Moving closer to the full time institutionalization end of the scale, there are the part-time hospital programs—the day hospital and the night hospital. Despite the fact that the day hospital is regarded by many psychiatrists as one of the most significant innovations in clinical care in this century, there were not more that several hundred patients receiving this type of care in the country in 1958 when a national conference was held on the subject. The Joint Commission report states that day hospitals can "provide an unique service for a large number of persons who do not need hospitalization but require more extensive help than that given by most mental hygiene clinics." It goes on to cite the advantages to the patient, the family, and to society through reduced economic cost. It is interesting to note the two major lines of development which day hospitals have followed: At one extreme are the treatment-oriented facilities with minimal emphasis on recreational or occupational therapy, while at the other extreme are the rehabilitation-oriented hospitals with school or workshop programs emphasizing vocational recreational and social

activities to help patients develop satisfying relationships and behave in ways acceptable to the general community.

The night hospital has been described as a psychiatric unit offering treatment to patients after working hours. While it has greater application for those who work and therefore less for the aged who typically are not in the labor market, it is worth noting as a significant unit on the range of services.[28]

Both day and night hospital programs for all intents and purposes are virtually nonexistent. Furthermore, the difficult financial situation in which mental programs find themselves, the pressures to develop new programs notwithstanding, appear to preclude development of these as well as other new programs.

This review of community-based services is not intended to catalog the variations and permutations of programs designed to keep the older person in the community and out of the mental hospital. It has not referred to the "half-way house," the function of the general hospital for certain types of services, so-called rehabilitation services, sheltered workshops, nursing homes, or ex-patient organizations. The emphasis here has been to point to the variety of programs which are already within our ken, which provide services to meet different needs of different patients; which are at once more humane and more economical since they can be used to meet the precise need of the individual without over- or under-providing for him; and which, in spite of all this, are virtually ignored in the development of the constellation of our health and welfare services.

Failure to appreciate the concept of prescribing specialized services to meet specialized needs, has resulted in reliance upon institutional programs which are the most expensive type of program in terms of costs per patient treated. The net result has been to withhold treatment from vast numbers of persons who are then forced in marginal existences.

LACK OF SERVICES AT THE HOSPITAL

The plight of State mental hospitals (which represent over 80 percent of all mental hospital beds) has been luridly detailed in annual reports of mental health departments, publications of mental health associations, and exposed to the public through all of the mass media. The basic nature of the State hospital in terms of its pressures to make a chronic illness out of an acute episode has been eloquently put by Dr. Robert Hunt, superintendent of the Hudson River State Hospital, New York as quoted in the Joint Commission Report:

> Much of the unnecessary crippling of the mentally ill must be laid at the door of the State mental hospital both from the standpoint of how it functions internally and how it is used by the society it serves. Despite the glorious early history of our State hospitals as first-rate treatment institutions; despite recent advances in the effectiveness of treatment; despite all the propaganda to the effect that these are hospitals for the treatment of the ill; despite the dedicated zeal of treatment-minded staff, commitment to the State hospital continues, in most cases, to represent to the patient and to his family major social surgery by "putting him away."
>
> A basic assumption in many reform waves seems to be that the addition of therapeutic tools and viewpoints to the mental hospital will automatically convert it from a custodial to a treatment institution * * *. The presence of a treatment-minded staff, and of humane and enlightened administration, doubtless mitigates some of the evils of the custodial function, but does not and cannot by itself abolish the function. The point I am trying to make is that the custodial culture within the mental hospital is in large part an inevitable consequence of the expectations of the population we serve. Our society hopes for successful treat-

ment, but it demands safe custody of those whom it rejects. The pressure for security is constant, unremitting, and a long accumulation of responses to this pressure for safe custody is embodied in hospital customs, traditions, regulations, laws, and architecture * * *. The custodial function] of the mental hopital is a necessary and inevitable product of the community demand and can never be abolished by measures taken within the hospital alone.[29]

If, then, this represents an intrinsic or constitutional factor in the mental hospital, it would seem to give emphasis to the contention that the hospital must concentrate on those elements of service which tend to relate it and its program to the community at large. This probably has implications for State mental health systems to develop an adequate network of intensive treatment centers, well staffed, manageable in size, and well related to the community in terms of intake and discharge processes. The Joint Commission on Mental Illness recommends with reference to the care of chronic mental patients, many of whom are in the aged group, that over the next 10 years all existing mental hospitals of more than 1,000 beds be converted to centers for the long-term and combined care of chronic diseases, including mental illness. It recognizes, however, that unless a certain dynamic is included in the program, we may achieve another arrangement for the disposal of our social rejects. It is careful to point out that special techniques are available for the care of this chronically ill group in the areas of rehabilitation, resocialization, and group living. But again, the report is emphatic in its concern for contact of such facilities with community services and clinics. The chronically ill, including the long-term mental patient, may well make use of sheltered workshops, foster care, halfway houses, and similar devices designed to redevelop social skills and reintegrate the individual in the community.[30]

To these points, we would add simply that major steps should be taken to substantially develop those services, particularly the social services, in the mental hospitals which represent the lines of contact with the community. That basic services in the mental hospitals and mental health programs are woefully lacking has been made evident. Some of this will be detailed further in the section of this report concerned with insufficient funds.

LACK OF FINANCES FOR MENTAL HEALTH PROGRAMS AND LACK OF FINANCIAL ABILITY OF THE STATES

While the problems of mental health programs are complex and cannot be ascribed to any single cause, there can be no doubt that the development of programs depends upon numbers of staff and the level of competence of staff. Very little data are available concerning the expenditures for some of the community-based services described above, much less information about that portion which affects mental health programs for the aged. There is, however, some information which is available for certain aspects of the mental health program.

Total appropriations for State hospitals, county hospitals for the mentally ill, and teaching and research hospitals rose from $568 million in 1954 to $813 million in 1958. The average amount of money spent daily for the care of each patient in 1958 reached $4.06, ranging from a low of $2.11 in Mississippi to a high of $6.17 in Kansas. The national average rose to $4.44 in 1959. At the same time, the mental

hospitals reversed an upward trend in the inpatient population, showing a decrease of 17,000 beginning in 1957.

Despite the increase in the daily per capita expenditures, it now appears that the wave of enthusiasm for mental health programs of the past few years may be levelling off and that mental health programs may be getting a smaller proportion of the tax dollar. In 1958, the proportion of general State expenditures for maintenance of patients in mental hospitals amounted to 3.25 percent, slightly down from the 3.31 percent of 1956. Less than half of the States spend more than 3 percent of their general budgets for the State hospital systems.

Even in terms of the percentage of tax dollars spent for health purposes, mental health appears to be experiencing some decline, dropping from 24.2 percent in 1957 to 22.8 percent in 1958.[31]

SOURCES OF MENTAL HEALTH FUNDS

The question of the potential for massive revenues for mental health purposes raises the question about where the money can come from, as well as whether the States have done as much as they can.

Some figures give indication of where the greatest potentials may lie. For instance, since 1946, according to the Bureau of the Census, State and local debt has risen 325 percent while the Federal debt has increased only 4 percent. On the other hand, State and local spending has risen 80 percent since 1950, while Federal spending has increased 35 percent in the same period of time.

Speaking before the annual Pennsylvania Citizens Association meeting in November 1960, Walter W. Heller, currently chairman of the President's Council of Economic Advisers, predicted an annual rate of economic growth of 4 percent, thus enabling the economy to achieve a gross national product of $750 billion by 1970. He pointed out that about 30 percent of the GNP in 1959 was plowed back into investments in plant and people. Ninety billion dollars, or 19 percent, went into physical investment. Investment in human beings—health, education, and welfare—took another $53 billion or 11 percent. National defense and foreign aid came to $46 billion or just under 10 percent. Thus, defense and human investment accounted for 40 percent, and consumer spending 60 percent of the GNP.

He goes on to project on the basis of a GNP of $750 billion that $92 billions could be implied for education, health, and welfare activities.

The growth in the economy which is thus contemplated will relieve to considerable extent the pressures on the Federal budget and intensify the pressures on State and local budgets. He said:

> Increasing affluence generates greater and greater demands on Government for services which improve human well-being and protect some of the basic amenities of life * * * better schooling, improved care for the mentally ill; expanded recreational facilities * * *.

All of the items typically fall in the realm of local-State governmental operations. It should be noted, too, that when the GNP grows by 3 percent personal income tax revenues grow by 4½ percent. At the same time, however, State and local revenues respond sluggishly.

Dr. Heller concludes that while States must redouble their efforts to exhaust all possible resources, the Federal Government will have ample revenues to expand its social service programs directly or to lend a helping hand to the States and localities. With $40 to $50 billion more of potential annual revenue available in 1970 than in 1960, the Federal Government should be ready to participate vigorously in a variety of social programs. Finally, he indicates that this contemplates no greater share of Government in the GNP, and would remain in its recent range of 26 to 29 percent of total national output.[32]

These conclusions by an eminent economist would seem to indicate the serious possibility of Federal participation in a large-scale grant-in-aid program to the States to improve the quality, scope, and organization of mental health programs in the States. Specific proposals are detailed in the section of this report concerned with issues for consideration.

FEDERAL PARTICIPATION

In the light of the current difficulties which the States are having in financing State mental health programs, consideration might be given to removing the prohibitions against Federal fiscal participation in public assistance grants made to persons residing in public medical institutions. As noted above, the aged arteriosclerotic, or even the quiet schizophrenic, may be found in any one of several institutional situations—in one the Federal Government may participate, while in another they may not. This sometimes leads to placement decisions based upon fiscal considerations rather than human ones. Removal of the current prohibition would make a difference of adding about 6 percent to current mental health budgets, provided the States were obliged to utilize such money as an increment to current programs rather than as a substitute for State revenues. The 6 percent estimate is based upon an assumption that 100,000 of the 165,000 elderly patients would be eligible, and that Federal funds of $50 per month per patient (actually almost the minimum available under existing formulas) would thus become available. This represents $5 million each month or $60 million a year.

LACK OF MANPOWER IN THE PROFESSIONS

The shortages of mental health professional personnel have been recited and well documented. While there was some improvement between 1956 and 1958, the fact remains the State hospitals still had only 57 percent of the number of needed physicians indicated by standards for hospitals and clinics of the American Psychiatric Association, 23 percent of the nurses, and 40 percent of the social workers. Only in the psychologist classification did the staffing begin to approach the recommended standard, and at that had reached 75 percent. Only two States, Kansas and Iowa, met the standard for physicians and only 50 percent of the States met 50 percent of the standard.

Professional man-hours spent in mental health clinics amounted to an average of 147 per 100,000 population in 1959—ranging from 10 man-hours per 100,000 people in Wyoming to 584 per 100,000 in Washington, D.C.

If general mental health services are deprived, the elderly patients in the chronic wards of the mental hospitals see a minor portion of what professional time there is. As for the clinics, the caseload of older persons is so minute that the shortage of help heaps further deprivation on a group already deprived of the opportunity for service.

How serious the shortage is, is revealed in surveys which demonstrate 25 percent of the budgeted positions for physicians and psychologists stand unfilled, while 20 percent of the budgeted positions for psychiatric nurses and social workers are similarly vacant.

The Joint Commission report explores the complex problems behind some of the shortages: The basic problem of an insufficient supply of physicians; the motivation of high school and college students to pursue careers in medicine; the problem of moving the graduate physician into the specialty of psychiatry or neurology; the lack of glamour of State hospital work; and the disparity in income potential between public and private psychiatry, as well as others, including a failure to achieve a real understanding with the general practitioners.

The field of social work presents one of the gloomiest pictures—there is an estimated general shortage of 50,000 social workers, and at the present time the schools of social work produce less than half of even the lowest estimates of graduates needed each year. Psychiatric social work, while holding "high status" within the profession, still constitutes but a small proportion of the field, and prospects for substantial improvement in the near future are doubtful under present circumstances.

While nursing has enjoyed some success in attracting young women into the profession, psychiatric nursing has been relatively unattractive. Five percent of the total supply of R.N.'s are in the psychiatric field, yet they are responsible for the care and supervision of half of all patients hospitalized on any given day. At current rates of attraction to psychiatric nursing, it must be anticipated that the shortages will grow.

This dismal picture of the prospects for the mental health field are a reflection of the problems which have been engendered in a system of education which fails to inspire and develop students for professional careers. Intellectual achievement has not had the values placed upon it that draws people into the professions. The distance from a poorly financed, poorly regarded, neglected system of education to the poorly staffed, poorly financed, poorly regarded system of mental health care is relatively short.

It would appear that radical new approaches to the care and treatment of the mentally ill are in order. It may be appropriate to reexamine who does what in the care of the patients, and to consider what treatment is and who can do it. Serious proposals have been advanced for permitting nonmedical workers with aptitude, sound training, practical experience, and demonstrable competence be allowed and encouraged to do short-term psychotherapy. We believe that this approach should be carefully examined and encouraged as an imaginative means of bringing more and better care to mental patients.

Only by dealing with the basic problems facing the mental health field as a whole will major impact be made on meeting the staff shortages in dealing with mental illness and the aged.

If is not the purpose of this report to discuss fully the massive problems of manpower in the field of mental health. These problems have received considered attention from the Joint Commission and its report should receive the most careful and serious attention.[33]

LACK OF DIRECTION IN RESEARCH EFFORTS

All of the foregoing difficulties, shortages and problems notwithstanding, the effectiveness of present mental health efforts to help the aged as well as all patients, is seriously hampered by the huge gaps in our present knowledge about mental illness and the ways in which we deal with it. The Federal Congress has recognized and supported research for mental health. In the decade 1950 to 1960 that the National Institute of Mental Health has been in existence, Congress has increased appropriations for NIMH from $8,700,000 in 1950 to $68 million in 1960. However, financial support is not enough. There is sore need for the development of research centers. The manpower needs in the operational programs are reflected in the research programs. The number of research institutes is limited and the amount of research taking place at the operational level is greatly limited. There is too little research taking place around organization of services and the effect of the services which we now offer. There is insufficient emphasis upon basic scientific research and overemphasis on research which assures results, thereby fettering the imaginative mind and making conservatism the order of the day in pursuit of knowledge.

Finally, it appears that the fruits of research are not being passed on quickly, accurately, thoroughly, and determinedly to the toilers in the vineyard—those medical personnel who are working with patients throughout the country. If it is being passed on, then we must recognize that for one reason or another it is not being accepted and put into practice. Perhaps we will have to explore this area as well. In the words of the report of the Joint Commission, what we seek is a balanced portfolio in mental research.

Overall, there must be some major directions provided, at least in the area of Federal participation. The heavy emphasis on project research through grants to a relatively small number of research institutions and universities has led to diffusion and lack of direction. This, we submit, should be reviewed in the light of determining whether there are specific goals or directions we wish to pursue.

III. ISSUES FOR CONSIDERATION

Because the problems of the aged and mental illness are so bound up in the entire rather unattractive mental health picture, the issues we present are, in the main, concerned with basic mental health programs. There are some, however, which have specific reference and application to the aged in particular.

A. Consideration should be given to the development of a large scale Federal grant-in-aid program to the States which would be based on a formula embodying the following premises:

1. State funds expended in mental health programs in the years in which the grant is made would be no less than the average annual amount applied and expended by the receiving State in the preceding 2 years.

2. The Federal share would match State expenditures on a scale which would provide for matching funds of 20 percent of State funds the first year, 40 percent the second year, up to a limit of 100 percent in the 5th year of participation.

3. The use of Federal funds for construction shall be limited to not more than 30 percent of the grant.

4. Expenditure of funds must be in accordance with some plan that alters the current uncoordinated pattern of mental hospitals, clinics and other community programs. Grants should be made on the basis of plans which show genuine integration of services with major social welfare programs, voluntary services, and community efforts.

5. Not less than 15 percent of the Federal funds shall be used for the development of services for the aged in the community, to be integrated administratively or otherwise with the major social welfare programs then current. Probably such funds should be granted either directly or in some joint arrangement with those State agencies which have the responsibility for the broad programs of public assistance and public welfare. It may be through this device of grants that the service amendment of 1956 to the Social Security Act can be better implemented.

6. The development of community services for the aged should include geriatric evaluation centers, operated on a communitywide basis and not merely on a mental health basis. These centers should be established for evaluation, counseling, referral, short-time hospitalization or treatment, outpatient service, counseling, etc.

This grant-in-aid program should be in addition to present and future programs of Federal grants-in-aid for research and training. The cost of the Federal program would approximate $200 million the first year; $400 million the second year of the program, and ultimately $1 billion in the 5th year, assuming that State expenditures for mental health will reach $1 billion annually in the near future.

B. The Social Security Act should be amended to remove the prohibition against Federal financial participation made to old-age-assistance recipients in mental hospitals. Consideration should be

given to the development of a formula which will channel the funds thus received into OAA grants to the mental health program for the benefit of the program rather than merely as a relief to existing pressures on State treasuries.

C. Because so many of the problems which receiving-hospital services are witnessing derive from poor physical and particularly nutritional origins, consideration should be given to the development of a hot lunch program, analogous to the Federal school lunch program for children. Under such a program, churches, day care centers, and other nonprofit, public or voluntary agencies might qualify to receive food through the Federal Government for the purpose of making available low cost, well-balanced meals for aged persons.

D. Consideration should be given to the development of services within the OASI program, inasmuch as this is the major contact for older people. Careful study should be given to the possibility of building in service elements to the program.

E. The field of manpower requires major alterations in our entire educational scheme. What is more, there is probably a serious need for substantial Federal grants for training. Equally important are the recommendations of the Joint Commission which focus upon the creation of images in order to establish a basic attraction to the field. Furthermore, the recommendation that the professionals take a long hard look at how professionals are deployed, whether "techniques" can be developed and whether psychiatrists are actually being utilized to provide the greatest good for the greatest number, is important. We would commend it to the public, private and professional groups concerned with the development of a greater pool of manpower.

F. Research:

1. Consideration should be given to development of a research policy by the Federal Government which would encourage and foster more basic research. This would undoubtedly require the making of long term grants, perhaps on a 10-year basis.

Closely allied to the development of long term basic research is a core of researchers. This may involve the possibility of long term appointments for scientific investigators.

3. Research policies and directions should be carefully developed at the Federal level in order to assure movement in given directions. The present project basis does not directly provide for this.

4. Arrangements and policies should be revised in order to provide for and encourage research into not only the "scientific" and clinical, but also in the sociological, administrative and organizational problems in mental health programing currently taking place. This assumes major importance where the field of aging is concerned, inasmuch as noted in this report, many of the problems faced by society today with reference to the aged and mental illness derive not so much from lack of knowledge of what to do or how to do it but rather from the poor utilization of what services we have and our failure to marshal our resources in optimum arrangements.

5. The development of research should be encouraged by provision of a grant program to establish additional research centers. These grants should make possible construction of institutes as well as assistance in operation.

FOOTNOTES

1. Data from Biometrics Branch, National Institute of Mental Health.
2. "Patients in Mental Institutions—1958," pt. 2, in publication Biometrics Branch, National Institute of Mental Health, "Current Population Reports, Population Estimate Series, p-25," 212, U.S. Bureau of the Census.
3. "Report on Patients Over 65 in Public Mental Hospitals, 1959," prepared by the American Psychiatric Association, Washington, D.C., pt. I, p. 5.
4. See note 1.
5. See note 2.
6. "Pattern of Retention, Release and Death of First Admissions to State Mental Hospital," by Pollack, Person, Kramer, and Goldstein, Public Health Monograph No. 58, 1959, Government Printing Office, p. 37.
7. "Review of a Pilot Study on Psychiatric Services in New York State," by Alvin I. Goldfarb, M.D. (Hektograph), 1958.
8. "Background Paper on Rehabilitation of Disabled, Mental, Aged and Older People," White House Conference on Aging, April 1960, p. 34.
9. Letter from Ben L. Grossman, as printed in "A Survey of Major Problems and Solutions in the Field of the Aged and Aging," Washington, 1959, p. 181.
10. Data from Office for the Aging, Pennsylvania Department of Public Welfare, Harrisburg, Pa.
11. "Action for Mental Health," final report of the Joint Commission on Mental Illness and Health, pp. 3–3 and 3–4. Basic Books, New York City, N.Y., 1960.
12. Ibid. 3–9.
13. Letter from Harry Levine, as printed in "A Survey of Major Problems and Solutions in the Field of the Aged and Aging," p. 84, Washington, 1959.
14. Greving, Frank, and Lourie, Norman V., "Restructuring Community Services for Orthopsychiatric Practice," unpublished, presented March 23, 1961, at the 38th annual meeting of the American Orthopsychiatric Association, New York City, N.Y.
15. Final report, Joint Commission, op. cit., p. 4–46.
16. Ibid. 4–47.
17. Ibid. 4–48.
18. Final report, Joint Commission, op. cit., 4–47.
19. Ibid., 4–68.
20. Ibid., 4–69.
21. Statement of Daniel Blain, M.D., Department of Mental Hygiene, Sacramento, Calif., 1959. "The Aged and the Aging in the United States (the Community Viewpoint)," hearings before the Subcommittee on the Problems of the Aged and Aging, p. 860–862.
22. Statement of Regis Downey, M.D., Mayview State Hospital, Mayview, Pa., "The Aged and the Aging in the United States (the Community Viewpoint)," hearings before the Subcommittee on the Problems of the Aged and Aging, Pittsburgh, 1959, p. 659.
23. Statement of Norman Coliver, United Community Fund, San Francisco, Calif., 1959, "The Aged and the Aging in the United States (the Community Viewpoint)," hearings before the subcommittee on the Problems of the Aged and Aging, p. 780.
24. "The Aged and Aging in the United States: A National Problem," a report together with minority view of the Committee on Labor and Public Welfare, U.S. Senate, made by its Subcommittee on Problems of the Aged and Aging, 1960, p. 151.
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26. "The Aged and Aging in the United States: A National Problem," op. cit., p. 153.
27. "Report on Patients Over 65 in Public Mental Hospitals," op. cit., p. 23.
28. Report of the Joint Commission, op. cit., pp. 4–169, 4–170.
29. Ibid., 2–47 et seq.
30. Ibid., 6–41.
31. Ibid., 1–7, 1–30.
32. PCA Reports, vol. IV, No. 20, Harrisburg, Pa., Dec. 6, 1960.
33. Report of the Joint Commission, op. cit., ch. 6.

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