Meeting the Needs of the Aged: The Social Worker in the Community Health Center

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OVER THE PAST YEAR, staff of Community Mental Health Centers (CMHC) across the country have expressed considerable interest in the development of mental health services for the elderly. The activity has been sparked in large measure by enactment of the 1975 Amendments (Public Law 94–63) to the Community Mental Health Centers Act of 1963 (Public Law 88–164). These amendments, which raise from 5 to 12 the number of essential services to be offered by a comprehensive CMHC, include the requirement that centers provide a full range of diagnostic, treatment, liaison, and followup services for aged persons.

The legislation confronts a problem that traditionally has plagued efforts to budget CMHC resources efficiently—decision making regarding the most effective expenditure of limited resources. Where and among which age groups will the expenditure of resources—fiscal and human—provide the greater payoff? The question may be related most directly to the issue of prevention, an important part of the CMHC program, but it also applies to other areas, for example, clinical services.

In fact, a review of the literature on community mental health centers' delivery of services to the elderly yielded little published information. Moreover, the role of the social worker generally in the mental health center or the social worker's role specifically with the aged client at a CMHC has received little attention.

The paucity of literature notwithstanding, a few centers do appear to offer services to the elderly. Reports from these centers describe much activity in the way of consultation and services to prevent mental illness, as for example, consultation on long-term care facilities (*1*) and centers for seniors as well as direct services in facilities where many aged persons reside (*2*). Many programs focus on supportive services which entail "fetch and carry" tasks or leisure group activities for aged persons. Few descriptions of clinical services delivered to the aged by CMHCs are available.

Several reasons account for the increasing concern over the mental health needs of the aged. While approximately 10 percent of the U.S. population are

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presently 65 years (*3*) or older and are considered to be a high-risk group for mental illness, roughly 3 percent of admissions to community mental health centers in 1974 were of persons in this age group. At the same time, longitudinal studies have shown that even among the so-called "normal" aged, depression is common (*4–6*).

A belief persists that among the aged a stigma is attached to the use of CMHC services and accounts for their low utilization of centers. The assumption warrants examination.

Undoubtedly, an older person's feelings of integration are threatened when he or she is experiencing problems remembering recent events and has suffered great losses. This threat may lead to a feeling of loss of control and, consequently, to a fear of being institutionalized for his or her safety. Such understandable fears are important considerations for center staff whether they are structuring the direct delivery of services or developing indirect mental health services for aged persons.

On the other hand, there seems to be little question that a built-in bias exists among a great majority of mental health professionals against offering services to the aged. Apparently, much of the recalcitrance involves the clinicians' own feelings about loss and death (*7*).

In an attempt to clarify this complex subject, I describe my perception of the professional social worker's role in general. Using my definition, I then briefly discuss some of the mental health problems of the aged in terms of stress, loss, and life crises. Finally, I offer some examples of ways to combine the social worker's role and skills with needed services in a manner helpful to elderly persons with mental health problems. The role of the CMHC with respect to former mental hospital patients is not described in this paper. Issues surrounding deinstitutionalized patients form the basis of the original and amended CMHC legislation and should be afforded separate discussion.

The Social Worker in the Mental Health Center

It takes courage to give a definition of the social worker's role, because this question has been under debate since I entered the field of social work and, to all appearances, it promises to remain so in the future. Nevertheless, my perception of the social worker's role includes among many characteristics the following: the social worker initiates and sustains a disciplined relationship with individuals, groups, and communities with an aim of ascertaining their social needs and the social resources to meet needs. The social worker's goal is to enable, on the basis of such an assessment of needs, the individual, group, or community to produce more satisfactory relationships for themselves in a constantly evolving society. The social worker is not trained to prescribe medicine, to give psychological tests, or to nurse patients. However, he or she should be able to realize the impact of all these services and to collaborate on behalf of the client with the appropriate, qualified care givers.

The social worker possesses a particular understanding of the individual person's role within the family group and the community and the impact of an individual's relationships within those frameworks. The social worker may be specially skilled in group dynamics or community organization. At all times, however, the social worker relies upon a "disciplined self"; that is, maintains an ability and a perspective that enables clients with whom she or he works to develop more satisfactory relationships.

The Experience of Stress in Aging

Consider the mental health of the elderly person in terms of stresses that, unattended, may adversely affect the development and maintenance of satisfactory relationships with other persons and institutions. The theme of loss and stress permeates this discussion. The life crises of the aged are not qualitatively different than those that may arise for younger persons. The crucial variable is that such losses—of a spouse, of physical abilities, of job and income—are expected as one ages, while to a younger person they are unanticipated and likely to be seen as cataclysmic. We often neglect to appreciate, however, that the trauma for the old can be as great or even greater than for the young, due to a time-compressed onslaught of losses. The following statistics from a U.S. Bureau of the Census report (*8*) illustrates graphically the mounting burden of loss and stress an older person is likely to experience.

In 1970, 58 percent of the population over the age of 65 were women, and 37 percent of the women between the ages of 65 and 69 were widowed. Widowhood rose to 61 percent among women between the ages of 75 and 79. Among men aged 65 to 69, only 9 percent were widowed; among men aged 75 to 79, 21 percent were widowed. The loss of a lifelong companion, the change in long-established habits and living arrangements, and loneliness and grieving understandably may generate a life crisis for the surviving spouse. Studies have shown that a widowed spouse may decline rapidly in health and appear to grieve his or her life away. And, as the statistics indi-

cate, many more women than men face this life crisis.

Retirement may present hazards for some aging persons. In March 1974, 79 percent of the male population between the ages of 55 and 64 were employed; 34 percent of men aged 65 to 69 were employed; and roughly 14 percent of men 70 or older were employed. Corresponding employment rates among women were ages 55 to 64, 42 percent; ages 65 to 69, 14 percent; and, by the age of 70 years, only 5 percent of all women over that age were employed. Thus with respect to retirement, it is primarily men who face this potential crisis. The loss of employment for many persons causes great anxiety and indeed a form of grief, not only over the loss of fulfilling job tasks but, more important perhaps, over the loss of relationships with fellow employees. For some persons who never achieved satisfactory use of their leisure time, the sense of disorientation can be profound, and a growing feeling of worthlessness can pervade the later years of life. Added to or resulting from these feelings, an individual may experience, for the first time, marital problems. When being with a spouse is a 24-hour proposition, rather than a limited time spent together before and after work hours, new facets of a relationship may appear.

The loss of income at retirement can add to the deficits felt by the retiree. In 1973, of persons between the ages 55 to 64, 14 percent had incomes of less than $6,000, 68 percent had incomes of more than $10,000, and the median income for that age group was $13,384. However, of persons aged 65 and older, 46 percent had incomes of less than $6,000 and only 28 percent had incomes of greater than $10,000. The median income for persons over 65 was $6,548, a little less than half of the median earnings between the ages 55 and 64. The inability to purchase what one has been accustomed to and needs is distressing, particularly for those living in a country where making money is so important to status and is a badge of success and respectability.

Another major stress is the loss of physical capacities taken for granted by many younger persons. The 1970 census statistics show that 26 percent of persons aged 60 to 64 years had a disability affecting their work. In 1972, approximately 43 percent of persons 65 and older were considered to have a limitation for a major activity. Significantly, a longitudinal study at Duke University (*4*) found a strong association between depressive feeling states and the older person's health status. To be profoundly dependent on others for routine life sustenance can be quite stressful. Such dependency can touch every life area including shopping for food, feeding oneself, cleaning oneself, dressing oneself, and even moving about.

Service Models for the Social Worker

In the various models I propose for the social worker's role in the CMHC, the aged person is viewed as the recipient of explicit mental health services. I focus on only three areas in which the social worker has the expertise to formulate a model for delivery of mental health services to aged persons; admittedly, there are more.

1. The social worker should be an expert on the diverse human services resources in the community, not only knowledgeable about them but also capable of making optimum use of them for the benefit of the mental health of the aged client. Many of these resources will be found outside the CMHCs; the social worker is the expert-in-residence on community resources to the other staff at the centers. Such staff competence is crucial, particularly in situations where the services offered by the center do not fit the mental health needs of the aged patient. Obviously, even an ideally staffed and programed CMHC cannot possibly meet all the mental health needs of the aged nor of other younger groups; thus, it must be determined how a center's direct services will be most effectively provided and used.

2. The social worker should be able to act as a consultant to other organizations and social agencies in interpreting the mental health needs of aged persons. Critically important in consultative activities is conveying knowledge about the vulnerability of the elderly to particular stresses. Ever mindful of unmet needs, the social worker can enhance the services of other agencies and organizations for the benefit of older persons.

3. With respect to direct services offered by a center, the social worker should emphasize to center staff the need for comprehensive care. While a center's immediate involvement is likely to be in the clinical sphere, adequate information is necessary to assess a person's social needs. The social worker should be able to see the effects of mental health problems on the patient's social relationships and identify and recommend resources that seem to fit his or her needs. The social worker cannot make up for these losses, cannot replace a meaningful job or a dead spouse, cannot recompense money lost with retirement, or cure the effects of physical incapacity. The social worker, however, can try to help the patient cope with and adapt to such losses while finding other resources to enhance his or her life.

Each of the four life crises discussed previously poses a need for certain direct and indirect services properly encompassed by the role and expertise of social workers on a center's staff. If the contribution of the social worker is as liaison to other agencies or facilities, such activity serves to make a center available to greater numbers of aged persons with mental problems. Linking with community resources may also aid in ameliorating some of the threat that aged persons feel in relating to a CMHC or in the mere idea of accepting help. Following are a few examples of approaches the center social worker might take in serving the aged.

Retirement has been described as a possibly stressful event for aged persons. How might a CMHC be constructively involved in the mental health aspects of this crisis? One suggestion is that center staff contact the personnel departments of industries either located in the catchment area or whose employees reside in the catchment area. The social worker might consult and cooperate with personnel department staff of those industries in designing and developing pre-retirement courses. If such courses already exist, the social worker could provide useful input to the curriculum regarding the implications for the mental health of employees facing retirement.

Taking a different tack, perhaps a center social worker could discuss with groups of pre-retirees what separation from lifelong tasks can entail. Since anxiety may only arise after the actual experience of retirement, and the pre-retiree may not be able to perceive or discuss it realistically, the center social worker, either directly or in consultation with other community resources, might help develop post-retirement groups to ease the aged person through what could be a stressful transitional period.

The loss of a spouse, another deeply traumatic experience, has prompted the development of various intervention programs to relieve the deep stress felt by the survivor. The widow-to-widow program which has been reported by Butler and Lewis (*9*) as helpful is a good example. While such programs are rare, they should be considered an important part of the center's program or created in other agencies through consultation with the center's staff.

The loss of physical capacities by the aged person —as well as possible severe depression resulting from this loss—may be most effectively handled by consultation to various long-term care facilities where aged persons reside. A social worker's consultation with the staff of these facilities should attempt to enable staff members to perceive what this trauma might mean to the aged person. Of course, the aged person who is making direct use of the CMHC should receive this same consideration in the evaluation of his mental condition, particularly when he appears to be depressed.

The reduction of income or physical incapacity, or both, which often follows retirement constitutes another source of concern for the mental well-being of elderly persons. The social worker should know about the resources for the aged person and be able to refer the patient appropriately. "Resources" in this case include not only money payments, but special transportation aids, nutrition programs, home health services, and similar activities.

Conclusions

I do not believe that the community mental health center should attempt to include all the mental health services that may be required by the aged client. Rather, staff social workers should direct their efforts toward optimal use of other community resources. The social worker may act as a liaison to these other agencies or, conceivably, help them directly. Needless to say, the social worker has a continual responsibility to assure that the center is doing its utmost to provide mental health services to the aged under the many circumstances where the need and provision is appropriate.

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