*A system of care for seriously mentally ill older adults incorporates concepts from programs for healthy older adults and challenges traditional concepts of mental health treatment.*

# An Innovative Program for Community-Residing Older Adults with Serious Mental Illness

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This chapter highlights the Community Connections Project, a program of innovative services for the seriously mentally ill elderly, funded as a three-year demonstration project by the Robert Wood Johnson Foundation. Since its inception in 1988, the project has served over 160 acutely or persistently mentally ill older adults each year. The project site, Senior Health and Peer Counseling in Santa Monica, California, has a fourteen-year history of providing innovative interdisciplinary health care services to older adults residing in the Westside of Los Angeles County.

In the sections that follow, we will introduce a philosophy of community-based mental health care derived from Senior Health and Peer Counseling's perspective and philosophy, address the need for services for seriously mentally ill older adults, and describe how the Community Connections Project uses formal and informal community supports to optimize the capacity of older people to function at reasonable levels of health and well-being.

## The Setting

Senior Health and Peer Counseling is a private, nonprofit organization founded in 1976 in response to a lack of affordable health care for older citizens. The Westside of Los Angeles County has a percentage of older people that is approximately twice the national average and that is growing rapidly. The majority of the services provided at the agency are not available through other public or private sources. Fees for services are on a sliding scale, according to an individual's ability to pay, and over 75 percent of clients are low income.

Programs focus on prevention of disease, education for a healthy lifestyle, and assistance with the special emotional concerns that aging brings. The complex health needs of older people are addressed through an interdisciplinary approach that takes into account the whole person—physical, emotional, and social. The use of volunteers is a hallmark of the agency's approach. It enables services to be extremely cost effective and adds a dimension of service that is enriching.

Senior Health and Peer Counseling offers several unique features that act as catalysts for success in serving the seriously mentally ill elderly. Providing services in a community-based interdisciplinary health care agency, as differentiated from a traditional mental health facility, creates a nonthreatening environment. People who come for services see active, healthy older adults participating as employees, as volunteers, as students, and as clients. Thus, the model diminishes the stigma so often attached to mental illness and traditional mental health facilities. Because of its philosophy of training and utilizing older adults as volunteers, the organization has received national attention, including exposure on *60 Minutes* and *20/20* and designation as one of President Bush's "Points of Light."

## Evolution of the Community Connections Project

The project has evolved in response to a wide range of needs.

**Local Need.** Santa Monica, California, has an unusually high proportion of older adults. In 1985, 27 percent of its population was age fifty-five or older, and the area had no public mental health services offered by specialists in gerontology or geriatrics. Additionally, more and more older adults with serious mental illness were being seen on the streets and at the agency, partially in response to a countywide funding crisis that resulted in the cutback of many mental health services in the mid 1980s. A revolving-door situation evolved in which there were less-than-adequate services to support people in the community and in which brief hospitalizations seemed to be the only treatment available for decompensating clients. While Senior Health and Peer Counseling was not staffed to serve this population in 1985, its overall concept has made the agency an ideal organization for developing a successful, well-utilized program that could offer services not otherwise available.

**National Need.** In addition to the community's particular situation, several other factors prompted Senior Health and Peer Counseling to invest in serving the chronically mentally ill senior. Older adults have a high prevalence of psychiatric problems, because of age-related changes (Srole and others, 1962; Kramer, Tauge, and Redick, 1973) such as increased physical illness, isolation and losses of social support, inadequate finances, and the association between age and organic mental

disorders (Butler and Lewis, 1982). Completed suicides among the elderly are disproportionately high, rising at succeeding age levels to a rate of 51.4 per 100,000 for white men age eighty to eighty-four (Pfeiffer, 1977). Even so, utilization of mental health services by older adults is lower than for any other age group except children (Zarit, 1980).

In California, older adults (age sixty plus) are grossly underfunded and underserved by mental health programs; although they represent 16 percent of the population, older adults received only 4 to 6 percent of mental health services, and it is estimated that 80 percent of older adults needing mental health services are not served by existing programs (Acosta, Cohen, Green, and Wulke, 1991).

One of the major system problems affecting older adults' use of mental health resources is that the community mental health movement of the 1960s and the resulting mental health programs took shape with younger populations in mind; planning did not adequately address the needs of older adults.

Although older adults across the country are underserved now with respect to mental health, long-range projections indicate an even worse state of crisis if planners do not respond to demographic projections that tell us of the aging of our population, both with respect to average life expectancy and to the overall percentage of older adults in the population (Atchley, 1985). According to U.S. Census figures, people sixty-five years of age and over currently number about 20.4 million. By the year 2030, this number will increase to 64.8 million. The fastest-growing segment of the elderly population, those age eighty-five and older, will be particularly vulnerable.

**Barriers to Access.** Why is mental health service utilization so sparse and inadequate? Unfortunately, many health care providers and older adults themselves foster the bias that older adults are not capable of benefiting from traditional treatments of choice for younger adults. Psychotherapy is a case in point. Although there has been a movement to dispel this myth, exemplified in Whelihan (1979), much work and advocacy must be done before service providers become enthusiastic about serving older adults.

Several other important barriers to access are addressed by Curian (1982). Government regulations, for example, still encourage institutional care rather than community care by restricting outpatient mental health care benefits. Psychological impediments to access include, for instance, asking minority seniors to trust "the establishment's" representatives, or expecting a cohort of adults not raised in an atmosphere of psychological-mindedness to seek out mental health services. Other more concrete access problems include transportation problems and need for outreach to homebound people.

It is clear that there is a great need to develop services in response to

the mental health needs of older adults. We share the opinion of Senator John Melcher (1988, p. 643) that "we need to switch the focus of our public assistance for health care away from institutional care and toward home and community-based medical and social services for elderly Americans. Both financial and humanitarian considerations point to this conclusion."

The Community Connections Project validated the impact of both traditional and innovative services in enhancing the quality of lives as well as the self-esteem of its seriously mentally ill participants. Aspects of the setting that facilitated access and ongoing participation are examined below.

## Description of the Project

The Community Connections Project is staffed by two clinical psychologists and a psychiatric social worker, with consultation from a psychiatrist and an occupational therapist. Based on an initial professional psychosocial assessment, the client and the professional agree on an individually tailored plan based on the client's special needs and strengths.

Clients with DSM-III-R Axis I or Axis II diagnoses are eligible for services (American Psychological Association, 1987). Because of other services in the area for the demented individual or the practicing alcoholic, these individuals are referred elsewhere. The only other restriction is for persons who can be considered to pose a risk of violence to others; the emphasis on mixing mentally ill and healthy participants does not provide for adequate security measures to work with violent clients.

The range of services includes psychiatric assessment and follow-up, individual and group counseling (by professionals, paraprofessionals, and interns), socialization (rehabilitative day care), care coordination (case management by professionals and volunteers), support groups, "healthy living classes," art therapy, and multiple volunteer opportunities for clients. In-home services are provided through a volunteer "care coordination program" that includes a professional assessment prior to volunteer assignments.

Professional intervention is used only as needed (for example, during periods of decompensation, for particularly complicated case management situations, for interagency "doctor-to-doctor" discussions). Seldom is a "therapist" the only source of support; a sense of community and of empowerment is created by fostering multiple supports and making new roles available to clients. Other nontraditional components include the very nature of the setting as described, the pairing of age-peer paraprofessionals with seriously mentally ill clients whenever appropriate, client volunteerism, a health education emphasis composed of classes and workshops open to the older adult public, and an organizational push toward empowerment and advocacy.

## Innovative Program Components

The program includes several innovative components.

**Peer Counseling.** Senior Health and Peer Counseling began peer counseling services in 1978, initially using trainers from the University of Southern California's Andrus Gerontology Center and other specialists in the field. As new groups of fifteen to twenty-five trainees were trained annually, Senior Health and Peer Counseling developed a specialized training program that was outlined in a manual—*Peer Counseling for Seniors: A Trainer's Guide*—published in 1986. Training efforts have expanded beyond the organization's volunteers. After being featured on *60 Minutes* in 1984, the model was replicated beyond Southern California. Trainings have resulted in the adaptation of the model in several states, and consultation with organizations have taken place in a variety of regions. The manual has been translated into Spanish and Danish, and it is being used to replicate programs across the country. In 1988, the National Institute of Mental Health, through a three-year grant administered by the California State Department of Mental Health, funded the organization to conduct training for peer counseling throughout the state. This project has prepared people at thirty-nine sites to train peer counseling volunteers.

The growing use of peer counseling is easily understood, because it is *affordable* and *acceptable* to older adults, and several studies have now been published that support the need for and value of these programs in a variety of settings (Hoffman, 1983; Losee, Aurebach, and Parham, 1988; Redburn and Juretich, 1989; Scharlach, 1988).

The use of peer counselors with seriously mentally ill clients has not been documented in the literature. Experiences at Senior Health and Peer Counseling demonstrate that, with proper support, peer counselors can be trained to work effectively with clients of this population once the clients have progressed from acute to more stable phases of their illnesses. From the outset of the Community Connections Project, peer counseling has been viewed as an invaluable resource along the continuum of services offered to seriously mentally ill clients.

**Volunteerism.** In keeping with its mission, Senior Health and Peer Counseling utilizes over 300 volunteers in a variety of roles. The literature highlights the beneficial effects to older adults of affiliation, social ties, and reciprocity (see Antonucci and Akiyama, 1991). Volunteers are honored for their work through recognition luncheons and the marking of special occasions, such as birthdays. Celebrations for staff and for volunteers as well as support during periods of loss are part and parcel of the organization and contribute to the sense of community. A monthly newsletter highlights volunteers, and it is with a great sense of pride that

Community Connections volunteers tell their stories. This is frequently the first time these clients have ever received any kind of positive recognition.

Volunteerism on the part of clients is an explicit objective of the Community Connections Project. Volunteerism provides affiliation, as well as the experience of productivity associated with "aging well" (Herzog and House, 1991). Volunteer projects are identified that provide opportunities for altruism and personal gratification leading to enhanced self-esteem. Included are an ongoing weekly crafts workshop, in which products are designed to benefit other groups such as children in the hospital, nursing home residents, and homebound elderly. Intergenerational projects are planned, the most long-standing being a *Grandfriends Program,* which has expanded to place volunteers at three nursery school sites. It is important to note that these projects are open to all volunteers, which results in a mix of relatively healthy adults and chronically mentally ill.

**Health Education.** A grant from the U.S. Department of Education has expanded this component of service; Senior Health and Peer Counseling and the Santa Monica Emeritus College offer ten "Healthy Living" classes targeted for older adults having, or at risk of having, serious mental illness. At least 50 percent of each class is "at risk." The classes are generally taught by mental health staff and often include special support groups facilitated by peer counselors. Instructors and support group leaders become important components of the client's expanding support network and treatment team. Examples of class subjects are memory, nutrition, depression, myths of aging, volunteering in one's community, one's unfinished past, and journal writing. The students' ratings of life satisfaction are monitored throughout their participation in the program.

**Advocacy.** Senior Health and Peer Counseling is committed to advocacy for the needs of older adults. The peer counseling model is in itself an important advocacy tool and has drawn national attention to the emotional needs of older adults over the past seven years through television programs such as *60 Minutes* and *20/20.*

The organization's leadership is active on local and state committees, in networking with other organizations, and in training of students from multiple disciplines. These efforts serve to inform the general public and the professional community as to the need for, and immense value of, services addressing the health and welfare of older adults.

Within the organization, clients' ideas are encouraged through their involvement on internal advisory committees. Clients are informed of and encouraged to participate in the organization's broader advocacy efforts through orientation-group discussions and through our monthly client newsletter. The emphasis is on self-help and on what can be done as a prescription for empowerment of older adults.

Constant threats of cutbacks of funding within Los Angeles county have frequently served as a mechanism to empower clients to take an active role in advocating for the continuation of services that benefit their lives. A recent funding crisis resulted in strengthening the organization's sense of community.

## Case Studies

Two case studies will help to give the preceding discussion a more concrete dimension.

Margaret was referred by another agency three years ago. At the time, she expressed feeling abandoned and was extremely suspicious and frightened about starting treatment. She lived alone and had unstable family support, no friends, and an extensive psychiatric history including several hospitalizations. Margaret was gradually introduced to services, beginning with weekly counseling sessions by a staff person. Extremely sensitive, she at first regretted her growing self-disclosure in sessions and called the therapist to express paranoid distortions about the sessions or to ask for demonstrations of caring. After several months, and two near hospitalizations, she agreed to see the agency's consulting psychiatrist for medication consultation. A medication was identified that greatly improved her paranoia and impulse control. Although her compliance waxed and waned, she was responsive to requests that she resume medication. Once relatively stable, she was eager to try other services and was introduced to a crafts workshop, where her sense of attachment and industry grew. She offered her services during center celebrations and became recognized for her hand-crafted centerpieces. Her growth extended to the greater community, where she joined a weight loss group, made some enduring friends, and won the state competition for weight loss last year. She also began to attend "Healthy Living" classes, which have given her an increasing comfort with peers. Although still vulnerable to stress, the client recaptures her strengths more quickly than in the past. She maintains a sense of integrity and connectedness to others that she reports as a new experience.

David was trained six years ago in the peer counseling program, but he has not seen peer counseling clients for several years due to periodic battles with major depression. A Christian Scientist, he has declined medication despite the serious symptoms of his recurrent disorder. Instead, he seeks emotional support from another peer counselor and maintains his sense of purpose by pursuing two less demanding volunteer tasks at the agency—friendly visiting and phone work in the intake office. A retired teacher, he maintains interest in continuing education,

and he is a frequent enrollee in the "Healthy Living" classes. David's peer counselor for four years has seen him through depressive episodes, continually reassuring him that they will pass, as indeed they do. When he has had suicidal ideation, he and the peer counselor receive extra support from agency professional staff; when free of symptoms, he and his counselor cut back their sessions to once a month, with phone support as needed. David's values and sense of self are preserved through the service modes offered him.

## Suggestions for Action

Our experience in consulting with other agencies with different demographics and needs tells us that the basic programmatic concepts presented in this chapter can be adapted to a variety of settings, such as hospitals, religious organizations, community mental health clinics, and any number of residential settings. The key elements to be incorporated are the pairing of professionals and paraprofessionals, flexibility to adapt services to client's changing needs, and opportunities for developing of strengths and a sense of community, such as client participation in student, volunteer, and advocacy roles.

Funding for mental health services to older adults is difficult to obtain, and for a nontraditional approach it is almost impossible to find. Senior Health and Peer Counseling could not have initiated the Community Connections Project without the willingness of the Robert Wood Johnson Foundation to support a unique project. Likewise, it could not be sustained without a diversified funding base consisting of extensive fundraising activities, public support directed primarily at case management and socialization, and some Medicare reimbursement. Other critical grants were obtained from the U.S. Department of Education for "Healthy Living" classes and from foundation support, which assisted in initiating Medicare billing. Indeed, attention to grant development of opportunities and private sector fundraising have been crucial to the continuation of the project.

The Community Connections Project furnishes an excellent example of an innovative approach for providing a continuum of mental health services to older adults that empowers and encourages participants to become involved with their communities. Utilizing older adults in paraprofessional volunteer roles makes the program cost effective and expandable. It establishes a system of care adaptable to clients' needs, resulting in high service utilization and low attrition. It is clear that the intervention incorporated reduces the incidence of hospitalizations, homelessness, and desperate acts, while improving clients' sense of integrity within a community. Community Connections is an approach that overcomes the barriers to mental health services for older adults.

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