

Mental Health Services for the Rural Aged: Public Policy Issues and Concerns

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Besides recognizing that there is a critical unmet and underemphasized need for mental health services for older Americans in general, researchers, in particular, have noted rural/urban differences in need for and utilization of mental health care services (Krout, 1998; Peterson & Maiden, 1993; Scheidt, 1985; Gatz & Smyer, 1992). Although it is not the purpose of this article to emphasize rural/urban differences, it is useful to make some comparisons to highlight rural needs and to address how these needs may be met. Rural areas are generally characterized as having elderly who are less willing to use services while having a greater need, partly due to environmental factors associated with rural life such as poorer health status, greater poverty and lack of specialized service providers (Clifford & Lilley, 1993; Rodeheaver & Datan, 1988).

The last census for which we have complete data (1990) revealed that 23 million elderly persons live in metropolitan areas while 8 million live in non-metropolitan areas. Although numerically more elderly people live in urban areas, a higher percentage of the population in rural areas is elderly (15%) as compared to metropolitan areas (12%).

Moreover, the 1990 census showed that the elderly represents one of the fastest growing segments (19%) of

the population compared to the growth for the rest of the population (10%). The old-old (above the age of 74) are the fastest growing segment (and the greatest users of health services) of the elderly rapidly increasing their needs for an already overstrained mental health system (Gatz and Smyer, 1992). This population is anticipated to double or triple in size over the next five to 10 years. In terms of mental health disorders, it has been estimated that about 18% to 33% of the elderly have at least one diagnosable mental health disorder (Belsky, 1990; Maiden & Peterson, 1991; Gatz & Smyer, 1992). While it is difficult to make rural/urban comparisons due to differing methodologies and the heterogeneity within and between rural and urban areas (Peterson & Maiden, 1993), Scheidt (1985) noted that a study conducted in Florida reported higher true rates of disorders in rural areas (33.3%), compared to urban areas (25.9%), while rural areas had lower treatment rates (5.3%) compared to urban areas (9.3%).

These figures may actually underestimate the general need for mental health services. For example, depression often is underestimated in older individuals as it is frequently misdiagnosed as a cognitive impairment, an organic disorder or a physical health problem (Gatz & Smyer, 1992; Rodeheaver & Datan, 1988). Furthermore, the old-old (particularly white males) have a very high suicide rate—although representing 12.4% of the population, elderly account for 21% of all suicides

(American Psychological Association, 1993). Moreover, a large proportion of the older adults seen in hospitals, clinics, and nursing homes (estimated to be 50% to 75%) have at least one mental health problem (American Psychological Association, 1993). If we include Alzheimer's disease and other dementias as a mental disorder, the need for mental health services by the elderly clearly matches or exceeds that of any other age group (McGuire, 1989).

While patients in nursing homes may be more likely to be referred to mental health specialists, the outpatient elderly in general, and the rural elderly in particular, seem not to receive mental health care services (Belsky, 1990). Roybal (1988) noted that less than 5% of elderly patients were seen at community mental health centers, and less than 2% were seen by private practitioners. Rathbone-McCuan (1993) cited a study in rural Minnesota, which reported about 20% of the elderly population presented with a significant mental health problem, whereas only 1% sought mental health care services. Indeed, underscoring the underutilization of services, McGuire (1989) noted that although people 55 years and older compose 21% of the elderly in the United States; they make up only 15.7% of the outpatient caseloads of psychiatrists and even more tragically 2.7% of the caseloads of psychologists.

In rural areas, these problems are further exacerbated by having fewer mental health care facilities and

professionals available, especially psychiatrists and psychologists (Menalascino and Potter, 1989). Benson has (2003a) explained that recruitment for geriatric specialists to work in rural areas is so difficult that specialties are filled by a limited number of psychiatrists, psychologists and social workers. Because of these deficiencies, the Department of Health and Human Services (HHS) has designated 60% of rural counties as mental health care shortage areas (Benson, 2003a). For example, it was noted in one study that Idaho had only 12 psychologists for 100,000 people (Benson, 2003b). The statistics are even worse for psychiatrists. A geographical area is considered underserved if it has a high elderly population and a population-to-psychiatrist ratio greater than 20,000:1. When we realize that only a small proportion of psychiatrists currently delegate a large proportion of their practice to treating the elderly, these figures are foreboding.

These findings are further exacerbated in rural areas by inadequate service delivery (Krout, 1998), serious transportation problems which restrict access to services by elderly individuals (even when the services are available) (Krout & Maiden, 2000; Peterson & Maiden, 1993), insufficient medical personnel, limited Medicare and Medicaid coverage for outpatient mental health care which disproportionately affects impoverished rural communities (Gelfand, 1984; McGuire, 1989) and older adults' lack of awareness of the types and purposes of

mental health services that are available within their communities (Roybal, 1988).

However, the situation is not completely bleak. Taietz and Milton (1979) noted that federal funding increases have decreased the rural/urban differences in available mental health services. Yet, while hard figures are hard to come by (Salmon et al., 1993), Roybal (1988) stated that the agencies delivering mental health care services in rural areas rarely have “the resources available to provide adequate let alone optimal care” for elderly individuals. DeCroix-Bane et al., (1994) reported that the National Resource Center for the Rural Elderly found that while rural areas reported more services than expected versus urban areas, significant gaps remained, especially in inpatient care resources.

These findings may have profound implications for policy-makers and funding agencies as the current systems are ill equipped to deal with this increased need and use of mental health care services (Coward and Cutler, 1989; Taietz and Milton, 1979). Moreover, the 78 million baby boomers on the heels of the current elderly cohort will flood these systems beyond their capacity to provide necessary services, particularly in rural areas (Krout & Maiden, 2000). Added to this, it is suspected that the aging baby boomers may be more prone to higher levels of depression, anxiety disorders and substance abuse than current elders, thereby further increasing the demands for services (Gatz & Smyer, 1992; Maiden,

2003).

To increase utilization of mental health care services, creative interventions are necessary. For example, mobile multidisciplinary teams of a psychiatrist or psychologist, nurse and social worker that conducted in-home mental health assessments increased the use of rural mental health care services (DeCroix-Bane, et al., 1994) from 4% to 21% of the agency's active clients who were 60 years or older.

Telecommunications or telehealth services may also be a creative method to reach individuals who live in remote rural areas. However, reimbursement has been one of the main barriers to utilization of telecommunication technologies (Benson, 2003b). The Balanced Budget Act of 1997 expanded the ability of the Health Care Administration (HCFA) to reimburse for telehealth activities. Yet, after two years, Medicare only reimbursed \$20,000 for teleconsultations. Confusion and interpretation of the policy were partially to blame. Other problems included fee splitting and only a 75% allotment of the normal payment. In addition, there were a limited number of procedural codes, allowed practitioners and variable state Medicaid regulations. Effective October 2001, Medicare reimbursements for telehealth were significantly changed to correct for these limitations, however; mental health care centers, nursing homes and rural telehome services were noticeably missing from this plan (Redford et al., 2001).

In summary, it has been estimated that 85% of the elderly with current mental health care needs go untreated (Rathbone-McCuan, 1993). In addition, because of the projected increase in numbers of the younger aged who are more likely to utilize services (Hayslip & Maiden, 2003; Gatz & Smyer, 1992), their need and use of mental health care services will increase dramatically. This increased demand represents a potent opportunity for psychiatrists, psychologists and other mental health care professionals trained in geriatrics to expand their clinical services by setting up practices in rural America and for professional organizations and governmental agencies to disseminate more vividly the need for mental health services and to advertise their availability.

Indeed, to encourage mental health professionals to move to rural areas the National Health Service Corps will repay their student loans (Kersting, 2003). A rural practice furnishes psychiatrists, psychologist and other mental health professionals with not only the opportunity to develop a viable practice but also to make a profound and palpable difference in the lives of the rural aged.

References

- American Psychological Association (1993), *Vitality for Life: Psychological Research for Productive Aging*. Washington, D.C.: American Psychological Association.
- Belsky JK (1990), *The Psychology of Aging: Theory, Research and Intervention*. Pacific Grove, Calif.: Brooks/Cole.
- Benson E (2003a), Beyond 'urbancentrism.' *Monitor on Psychology* 34(6):54-55.
- Benson E (2003b), Telehealth gets back to basics. *Monitor on Psychology* 34(6):58-59.
- Clifford WB, Lilley SC (1993), Rural elderly: their demographic characteristics. In: *Aging in Rural America*, Bull CN, ed. Newbury Park, Calif.: Sage Publications, pp3-16.
- Coward RT, Cutler S (1989), Informal and formal health care systems for the rural elderly. *Health Services Research*, 23(6):785-806.
- DeCroix-Bane S, Rathbone-McCuan E, Galliher J (1994), Mental health services for the elderly in rural America. In: *Providing Community-Based Services to the Rural Elderly*, Krout J, ed. Thousand Oaks, Calif.: Sage Publications.
- Gatz M, Smyer MA (1992), The mental health system and older adults in the 1990s. *American Psychologist*, 47(6):741-71.

- Gelfand DE (1984), *The Aging Network: Programs and Services*. New York: Springer.
- Hayslip, B., & Maiden, R.J. (2003, August), Attitudes toward mental health care among rural and urban elderly persons. Presented at the American Psychological Association's Annual Convention, Toronto, Canada.
- Kersting K (2003), Teaching self-sufficiency for rural practice. *Monitor on Psychology* 34(6):60-62.
- Krout JA (1998), Service and service delivery in rural environments. In: *Aging in Rural Settings: Life Circumstances and Distinctive Features*, Coward RT and Krout JA, Eds. New York: Springer.
- Krout JA, Maiden RJ (2000), Living in the Community: A Rural and Nonrural Comparison. In: *Project 2015: The future of aging in New York*. Albany, N.Y.: New York State Office for Aging.
- Maiden, RJ (2003), Mental Health Services for the Rural Aged. *Psychiatric Times*, 20, No. 12, pp. 41-46.
- Maiden RJ, Peterson SA (1991), Strain, social support, personality, and the use of counseling services in rural older Americans. Presented at the Gerontological Society of America's Annual Meeting, San Francisco.
- McGuire TG (1989), Outpatient benefits for mental health services in Medicare: alignment with the private sector? *American Psychologist* 44(5):818-824.

- Menalascino FJ, Potter JF (1989), Delivery of services in rural settings to the elderly mentally retarded-mentally ill. *International Journal of Aging & Human Development*, 28(4):261-275.
- Peterson SA, Maiden RJ (1993), *The Public Lives of Rural Older Americans*. New York: University Press of America.
- Rathbone-McCuan E (1993), Rural geriatric mental health care: a continuing service dilemma. In: *Aging in Rural America*, Bull CN, ed. Newbury Park, Calif.: Sage Publications, pp146-169.
- Redford L, Cook D, Longino CF (2001) Rural health care in transition: The role of technology. *Public Policy & Aging Report* 12(1):1-5.
- Rodeheaver D, Datan N (1988), The challenge of double jeopardy. Toward a mental health agenda for aging women. *American Psychologist*, 43(8):648-654.
- Roybal ER (1988), Mental health and aging: The need for an expanded federal response. *American Psychologist*, 43(3):189-194.
- Salmon MA, Nelson GM, Rous SG (1993), The continuum of care revisited: a rural perspective. *Gerontologist* 33(5):658-666.
- Scheidt RJ (1985), The mental health of the aged in rural environments. In: *The Elderly in Rural Society*, Coward RT and Lee GR, eds. New York: Springer.
- Taietz P, Milton S (1979), Rural-urban differences in the structure of services for the elderly in upstate New

York counties. *Journal of Gerontology*, 34(3):429-437.