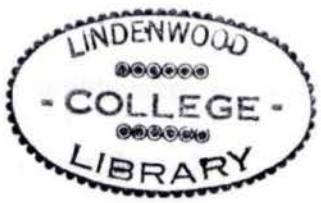
1994

The Need for a Specialized Treatment Center for the Elderly Population in St. Charles County

Sandi Klein

THE NEED FOR A SPECIALIZED TREATMENT CENTER FOR THE ELDERLY POPULATION IN ST. CHARLES COUNTY



Sandi Klein, B.S.

An Abstract Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Gerontology

1994

Abstract

A most recent trend in the field of psychiatric health care has been to provide services for the elderly on highly specialized "geropsychiatric units" located within the confines of a general hospital and operated as a new component of the psychiatric treatment divisions.

Four local hospitals were surveyed regarding their in-patient mental health services for the elderly. The goal was to identify where geropsychiatric services were currently being offered and if their services were located on a special geropsychiatric unit, specific only to those patients over 65 years of age. Each hospital was surveyed as to the types of staff working on these units (RN's, Social Workers, Psychologists, Medical Director, Activity Therapists, etc.), their individual backgrounds and previous experience with the elderly, the various types of assessment tools utilized and various components of the individual programs. The hospitals surveyed were: De Paul Hospital, Christian Hospital Northwest, St. Anthonys Psychiatric Center and Barnes - St. Peters Hospital.

The survey clearly supported the premise that general hospitals with psychiatric services will experience a dramatic increase in the

number of elderly patients seeking mental health services and that this population has special needs relating specifically to age.

Each hospital representative confirmed that their specific review of the demographics of the population within their service areas, along with the national projections for increase in the surviving elderly population, compared directly to their respective admissions data of more services being provided for the elderly, especially in the areas of counseling and psychiatric services. These needs are currently being met by the hospitals surveyed, on the geropsychiatric units which they have already developed -- which emphasize treatment services separate from their acute, adult (younger) psychiatric patients.

This paper will report on the results of the survey and discuss the need and justification for developing a geropsychiatric unit at St. Joseph Health Center - St. Joseph Hospital West in St. Charles County, Missouri.

THE NEED FOR A SPECIALIZED TREATMENT CENTER FOR THE ELDERLY POPULATION IN ST. CHARLES COUNTY

Sandi Klein, B.S.

A Culminating Project Presented to the Faculty of the
Graduate School of Lindenwood College in Partial
Fulfillment of the Requirements for the
Degree of Master of Arts in Gerontology
1994

COMMITTEE IN CHARGE OF CANDIDACY

Marilyn Patterson, Ed, D., Assistant Professor
Faculty Advisor - Lindenwood College

Betty Lemasters, PhD., Assistant Professor
Lindenwood College

Lynette Gerschefske, R.N., Vice President Patient Services
St. Joseph Health Center - St. Joseph Hospital West

DEDICATION

To my husband, Glenn

and my children, Christian and Jennifer.

TABLE OF CONTENTS

	Page
Chapter I - Purpose	1
Chapter II - Literature Review	3
Chapter III - Methodology	27
Chapter IV - Results	30
Chapter V - Conclusion and Proposal	37
Appendix A	53

LIST OF FIGURES

		Page
Figure 1	Actual and Projected Growth . . . . . of the Older Population, 1990-2050	3
Figure 2	Number and Percent Distribution of the . Population, By Age: United States Selected Calendar Years 1987-2030	5
Figure 3	Projections of the Elderly Population, . . . by Age: 1990-2050.	6
Figure 4	Percentage of 85-Plus Persons in the . . . . Elderly Population, 1960-2050.	7
Figure 5a	Census, Estimated and Projected . . . . . St. Charles County	9
Figure 5b	Census, Estimated and Projected . . . . . Warren County	10
Figure 5c	Census, Estimated and Projected . . . . . Lincoln County	11
Figure 5d	Census, Estimated and Projected . . . . . Pike County	12
Figure 6	1986 San Diego Suicide Study	15

CHAPTER I

Purpose

The purpose of this paper is to review the variety of information regarding the treatment of the elderly population for mental health problems and to justify the need for geropsychiatric services in St. Charles County. The information, both in charts and summary format, provide a solid foundation for the development of a highly specialized geropsychiatric treatment unit. A survey is included of the currently existing geropsychiatric units in the metropolitan St. Louis area and reveals the absence of such a unit in the St. Joseph Health Center's primary catchment area - specifically, St. Charles, Warren, Lincoln and Pike counties. This paper demonstrates a precise need for such a unit and concludes with a realistic proposal for a geropsychiatric treatment facility to be developed by St. Joseph Health Center - St. Joseph Hospital West.

THE LITTLE BOY AND THE OLD MAN

Said the little boy, "Sometimes I drop my spoon."

Said the little old man, "I do that too."

The little boy whispered, "I wet my pants."

"I do that too," laughed the little old man.

Said the little boy, "I often cry."

The old man nodded, "So do I."

"But worst of all," said the boy, "It seems

Grown-ups don't pay attention to me."

And he felt the warmth of a wrinkled old hand.

"I know what you mean," said the little old man.

CHAPTER II

Literature Review

America Grows Older

The elderly are the fastest growing segment of the U.S. population. According to the U.S. Bureau of Census in 1900, one American out of every 25 (4% of the total population) was over 65 years old. The 65+ age group made up 12.4 percent of the total population in 1989 and by 2050, 21.8 percent of the U.S. population will be 65 or older - more than 1 person out of every 5. (Figure 1, Information Plus, 1990, p. 3).

FIGURE 1

Actual and Projected Growth of the Older Population, 1900-2050

Year	Total population all ages	55 to 64 Years		65 to 75 Years		75 to 84 Years		85 Years & Older		85 Years and Over	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1900	76,303	4,009	5.3	2,189	2.9	772	1.0	123	0.2	3,084	4.0
1910	91,972	5,054	5.5	2,793	3.0	989	1.1	167	0.2	3,950	4.3
1920	105,711	6,532	6.2	3,464	3.3	1,259	1.2	210	0.2	4,933	4.7
1930	122,775	8,397	6.8	4,721	3.8	1,641	1.3	272	0.2	6,634	5.4
1940	131,669	10,572	8.0	6,375	4.8	2,278	1.7	365	0.3	9,019	6.8
1950	150,967	13,295	8.8	8,415	5.6	3,278	2.2	577	0.4	12,270	8.1
1960	179,323	15,572	8.7	10,997	6.1	4,633	2.6	929	0.5	16,560	9.2
1970	203,302	18,608	9.2	12,447	6.1	6,124	3.0	1,409	0.7	19,980	9.8
1980	226,505	21,700	9.6	15,578	6.9	7,727	3.4	2,240	1.0	25,544	11.3
1990	249,657	21,051	8.4	18,035	7.2	10,349	4.1	3,313	1.3	31,697	12.7
2000	267,955	23,767	8.9	17,677	6.6	12,318	4.6	4,926	1.8	34,921	13.0
2010	283,238	34,848	12.3	20,318	7.2	12,326	4.4	6,551	2.3	39,195	13.8
2020	296,597	40,298	13.6	29,855	10.1	14,486	4.9	7,081	2.4	51,422	17.3
2030	304,807	34,025	11.2	34,535	11.3	21,434	7.0	8,612	2.8	64,581	21.2
2040	308,559	34,717	11.3	29,272	9.5	24,882	8.1	12,834	4.2	66,988	21.7
2050	309,488	37,327	12.1	30,114	9.7	21,263	6.9	16,034	5.2	67,411	21.8

Sources: 1900-80: U.S. Bureau of the Census, Decennial Censuses of Population 1990-2050: U.S. Bureau of the Census, Projections of the Population of the United States, by Age, Sex, and Race: 1983 to 2030. Current Population Reports, Series P-25, No. 952, May 1984. Projections are middle series.

Why is America getting older? Information found from Social Security Administration data states that one of the main reasons is that during the 20 years after World War II there was an explosion of births. Children born during these years made up what is called the "baby boom generation." These baby boomers will begin to turn 65 around 2010. The 65+ population will then increase dramatically between 2010 and 2030 as the baby boomers make their transition from "not old" and "old." The total U.S. population will increase by 20 percent between 1987 - 2030, but the number of Americans over 65 years of age will grow by more than 50% during that time (Figure 2, Information Plus, 1990, p. 4).

FIGURE 2

Number and percent distribution of the population, by age:
United States, selected calendar years 1987-2030

Age	1987	2000	2010	2020	2030
			Population in millions[1]		
Total	251.8	277.3	293.4	307.7	318.8
Under 20 years	73.4	75.9	73.8	74.2	74.4
20-64 years	148.1	165.8	179.6	180.6	175.9
65 years or over	30.2	35.6	40.0	52.8	66.5
65-69 years	9.8	9.6	12.2	17.6	19.0
70-74 years	7.8	8.9	9.1	13.8	17.3
75-79 years	5.8	7.4	7.1	9.2	13.3
80-84 years	3.7	5.1	5.6	5.8	9.0
85 years or over	3.0	4.6	6.0	6.5	7.9
			Percent distribution of total population		
Total	100.0	100.0	100.0	100.0	100.0
Under 20 years	29.2	27.4	25.2	24.1	23.5
20-64 years	58.8	59.8	61.2	58.7	55.5
65 years or over	12.0	12.8	13.6	17.2	21.0
65-69 years	3.9	3.5	4.2	5.7	6.0
70-74 years	3.1	3.2	3.1	4.5	5.5
75-79 years	2.3	2.7	2.4	3.0	4.2
80-84 years	1.5	1.8	1.9	1.9	2.8
85 years or over	1.2	1.7	2.0	2.1	2.5
			Percent distribution of aged population		
85 years or over	100.0	100.0	100.0	100.0	100.0
65-69 years	32.5	27.0	30.5	33.3	28.6
70-74 years	25.8	25.0	22.7	26.1	26.0
75-79 years	19.2	20.8	17.8	17.4	20.0
80-84 years	12.3	14.3	14.0	11.0	13.5
85 years or over	9.9	12.9	15.0	12.3	11.9

[1] Social Security area populations as of July 1.

NOTES: Population growth is taken from the intermediate (II-B) assumptions used to prepare the *1989 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Fund.* Totals may not add to 100.0 because of rounding.

SOURCE: Social Security Administration: Data from the Office of the Actuary.

The U.S. Bureau of Census further states that even more dramatic than the growth of the 65+ population will be the increase in the number of Americans over the age of 85 (Figure 3). While the 65 to 84 age group will decline slightly after 2030, the number of people over 85 will continue to grow through 2050. By 2050, the 85+ age group will make up 5% of the total U.S. population and over 22% of the 65+ age group. (Figure 4, Information Plus, 1992, p. 4).

FIGURE 3

Source: Bureau of the Census

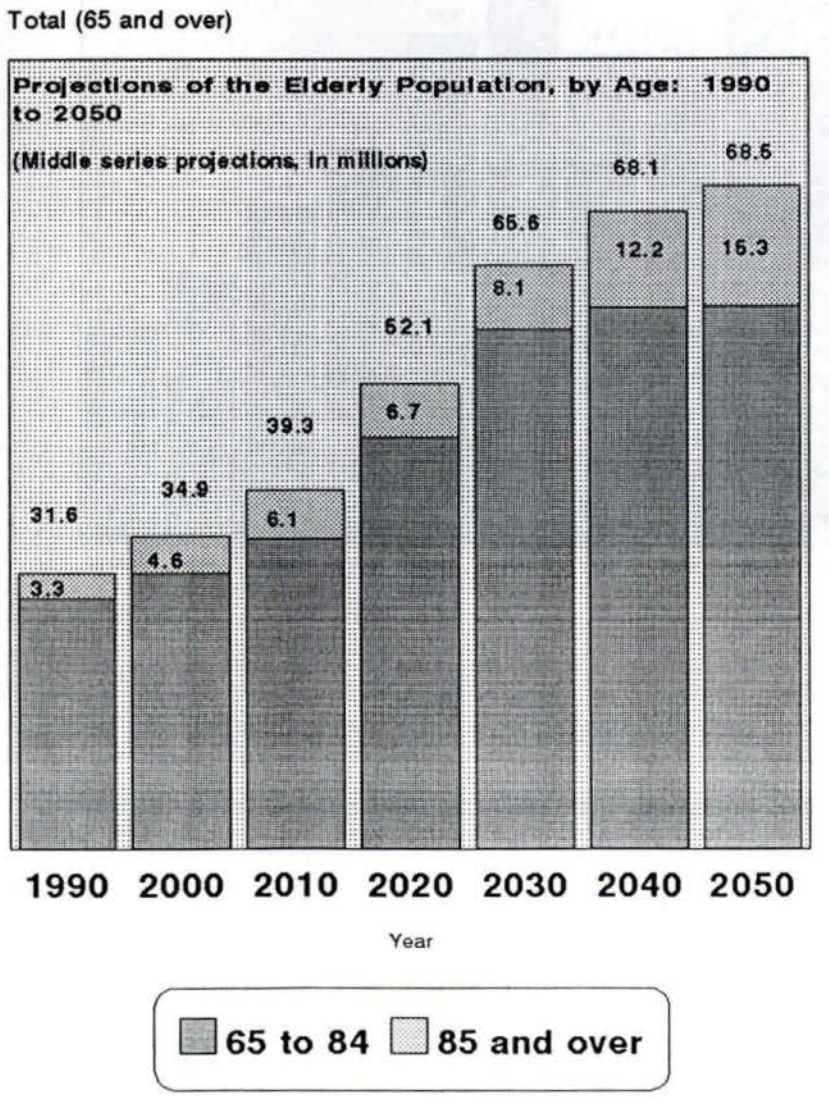
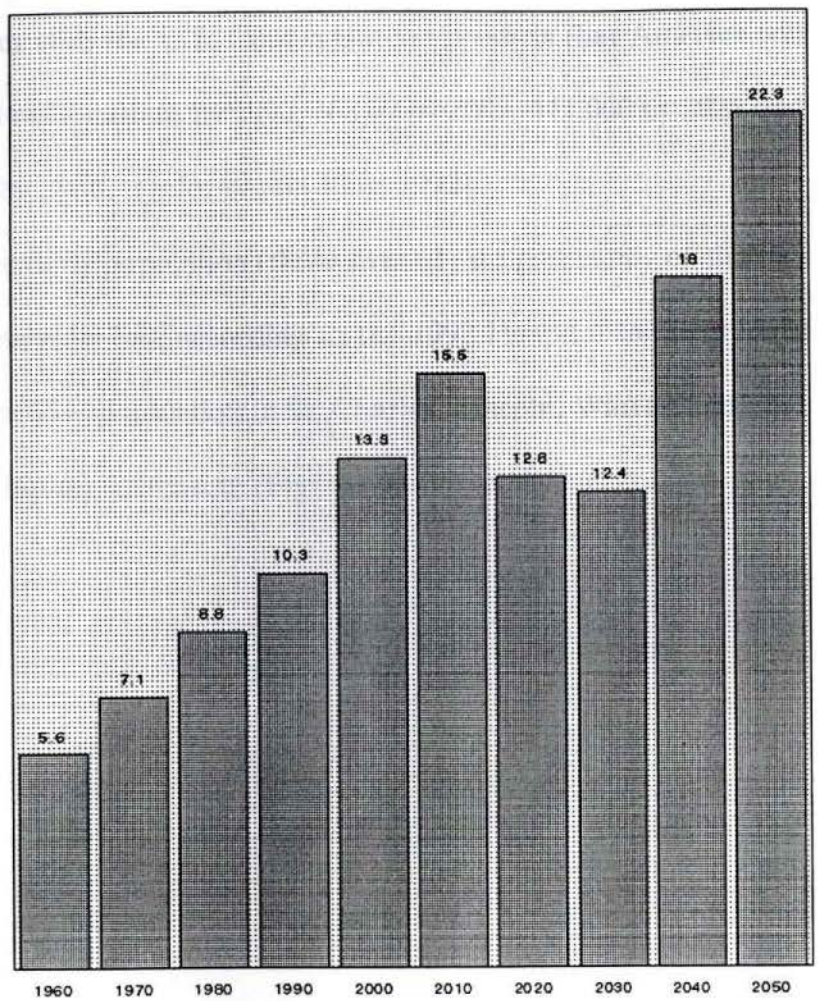


FIGURE 4
Percentage of 85-Plus Persons in the Elderly Population, 1960-2050



Source: U.S. Census Bureau, Current Population Reports

According to the U.S. Bureau of the Census and the Metropolitan Life Insurance Company the U.S. will experience a "centenarian boom" within the next 60 years. The chances of living to age 100 have increased 40 times since 1900. Dr. Gregory Spencer, a demographer with the U.S. Census Bureau predicts that America will have 54,000 centenarians by 1990, 108,00 by 2000, 441,000 by 2025 and 1.3 million by 2050. (Information Plus, 1992).

The elderly population (those over 65) is significantly on the rise not only nationally but, according to the 1992 Hospital Industry Data Institute, the 65+ population in St. Charles, Lincoln, Warren and Pike counties is rapidly increasing (Figures 5, a, b, c, d).

FIGURE 5a

MISSOURI
ST. CHARLES COUNTY (183)
ST. LOUIS, MO-IL MSA

CENSUS, ESTIMATED AND PROJECTED DATA - 1992 DATA
HOSPITAL INDUSTRY DATA INSTITUTE

POPULATION CHARACTERISTICS	1980 CENSUS	1990 CENSUS	1992 ESTIMATE	1997 PROJECTED	%CHNG 90-92
POPULATION	144,106	212,907	227,579	263,774	6.89
PCT OVER 65	6.02	6.90	7.07	7.35	2.49
HOUSEHOLDS	46,471	74,331	80,230	95,829	7.94
POP/HOUSEHOLD	3.07	2.83	2.81	2.72	-0.98
FAMILIES	38,620	57,815	61,680	71,730	6.69
HOUSING UNITS	50,027	79,113	85,218	101,546	7.72
POP GRP QTRS	1,283	2,225	2,397	2,834	7.73

POPULATION BY AGE AND SEX

COUNTY	AGE	1990 CENSUS TOTAL	%	MALE	FEMALE	1992 ESTIMATE TOTAL	%	MALE	FEMALE	%CHNG 90-92	1997 PROJECTED TOTAL	%	MALE	FEMALE
ST. CHARLES	0- 4	19,023	8.9	9,896	9,127	20,716	9.1	10,780	9,936	8.9	22,853	8.7	11,901	10,952
	5- 9	19,080	9.0	9,701	9,379	20,164	8.9	10,256	9,908	5.7	23,683	9.0	12,050	11,633
	10-14	17,006	8.0	8,624	8,382	18,594	8.2	9,428	9,166	9.3	21,660	8.2	10,989	10,671
	15-17	8,958	4.2	4,598	4,360	9,089	4.0	4,672	4,417	1.5	11,053	4.2	5,676	5,377
	18-20	8,062	3.8	4,049	4,013	8,237	3.6	4,143	4,094	2.2	9,440	3.6	4,753	4,687
	21-24	11,081	5.2	5,338	5,743	11,501	5.1	5,548	5,953	3.8	11,467	4.3	5,540	5,927
	25-29	20,331	9.5	9,908	10,423	20,040	8.8	9,732	10,308	-1.4	20,847	7.9	10,077	10,770
	30-34	22,287	10.5	10,995	11,292	23,596	10.4	11,642	11,954	5.9	24,217	9.2	11,919	12,298
	35-39	19,259	9.0	9,448	9,811	21,077	9.3	10,363	10,714	9.4	24,637	9.3	12,159	12,478
	40-44	16,915	7.9	8,503	8,412	18,618	8.2	9,376	9,242	10.1	23,163	8.8	11,729	11,434
	45-49	12,880	6.0	6,646	6,234	14,881	6.5	7,660	7,221	15.5	19,536	7.4	10,076	9,460
	50-54	9,263	4.4	4,753	4,510	10,397	4.6	5,329	5,068	12.2	14,731	5.6	7,555	7,176
	55-59	7,623	3.6	4,015	3,608	7,969	3.5	4,208	3,761	4.5	10,087	3.8	5,331	4,756
	60-64	6,447	3.0	3,114	3,333	6,605	2.9	3,206	3,399	2.5	7,002	2.7	3,426	3,576
	65-69	5,335	2.5	2,512	2,823	5,511	2.4	2,593	2,918	3.3	5,898	2.2	2,829	3,069
	70-74	3,621	1.7	1,567	2,054	4,069	1.8	1,782	2,287	12.4	4,713	1.8	2,084	2,629
	75-79	2,601	1.2	979	1,622	2,864	1.3	1,098	1,766	10.1	3,690	1.4	1,481	2,209
	80-84	1,711	0.8	528	1,183	1,949	0.9	618	1,331	13.9	2,545	1.0	855	1,690
	85+	1,424	0.7	318	1,106	1,702	0.7	394	1,308	19.5	2,552	1.0	627	1,925
	MEDIAN AGE	30.7		30.3	31.0	31.2		30.8	31.5		32.2		31.9	32.6

INCOME CHARACTERISTICS

COUNTY	HOUSEHOLD INCOME ($)	1979 NUMBER	%	1989 NUMBER	%	1992 NUMBER	%	1997 NUMBER	%	%CHNG 89-92
ST. CHARLES	UNDER 15,000	12,223	26.3	8,426	11.3	7,676	9.6	7,288	7.6	-8.9
	15,000-29,999	22,228	47.8	15,485	20.8	15,137	18.9	14,606	15.2	-2.2
	30,000-49,999	10,278	22.1	24,339	32.7	24,350	30.4	24,447	25.5	0.0
	50,000-74,999	1,291	2.8	18,582	25.0	21,300	26.5	27,341	28.5	14.6
	75,000 & ABOVE	451	1.0	7,499	10.1	11,767	14.7	22,147	23.1	56.9
	MEDIAN HHOLD INC	22,422		40,323		44,126		51,181		9.4
	AVERAGE HHOLD INC	23,715		43,721		49,523		59,777		13.3
	PER CAPITA INCOME	7,677		15,343		17,550		21,840		14.4
	MEDIAN FAMILY INCOME	24,166		45,064		49,249		57,063		9.3

FIGURE 5b

MISSOURI
WARREN COUNTY (219)

CENSUS, ESTIMATED AND PROJECTED DATA - 1992 DATA
HOSPITAL INDUSTRY DATA INSTITUTE

POPULATION CHARACTERISTICS

	1980 CENSUS	1990 CENSUS	1992 ESTIMATE	1997 PROJECTED	%CHNG 90-92
POPULATION	14,900	19,534	20,519	22,938	5.04
PCT OVER 65	15.23	13.83	14.04	14.33	1.51
HOUSEHOLDS	5,141	7,070	7,437	8,389	5.19
POP/HOUSEHOLD	2.85	2.73	2.73	2.70	-0.15
FAMILIES	4,110	5,423	5,638	6,193	3.96
HOUSING UNITS	6,538	8,841	9,281	10,444	4.98
POP GRP QTRS	253	232	246	280	6.03

POPULATION BY AGE AND SEX

		1990 CENSUS				1992 ESTIMATE				%CHNG	1997 PROJECTED			
COUNTY	AGE	TOTAL	%	MALE	FEMALE	TOTAL	%	MALE	FEMALE	90-92	TOTAL	%	MALE	FEMALE
WARREN	0- 4	1,599	8.2	810	789	1,707	8.3	865	842	6.8	1,808	7.9	917	891
	5- 9	1,626	8.3	816	810	1,688	8.2	848	840	3.8	1,908	8.3	959	949
	10-14	1,480	7.6	750	730	1,592	7.8	807	785	7.6	1,789	7.8	908	881
	15-17	780	4.0	400	380	776	3.8	399	377	-0.5	907	4.0	466	441
	18-20	699	3.6	376	323	703	3.4	378	325	0.6	773	3.4	417	356
	21-24	868	4.4	407	461	886	4.3	416	470	2.1	846	3.7	399	447
	25-29	1,515	7.8	751	764	1,459	7.1	723	736	-3.7	1,431	6.2	711	720
	30-34	1,650	8.4	845	805	1,709	8.3	876	833	3.6	1,662	7.2	851	811
	35-39	1,503	7.7	770	733	1,623	7.9	833	790	8.0	1,825	8.0	940	885
	40-44	1,249	6.4	624	625	1,354	6.6	678	676	8.4	1,638	7.1	825	813
	45-49	1,060	5.4	532	528	1,210	5.9	608	602	14.2	1,543	6.7	780	763
	50-54	1,061	5.4	528	533	1,157	5.6	576	581	9.0	1,540	6.7	767	773
	55-59	934	4.8	475	459	961	4.7	489	472	2.9	1,154	5.0	587	567
	60-64	808	4.1	400	408	813	4.0	405	408	0.6	828	3.6	416	412
	65-69	857	4.4	405	452	871	4.2	412	459	1.6	901	3.9	435	466
	70-74	702	3.6	335	367	765	3.7	367	398	9.0	847	3.7	408	439
	75-79	524	2.7	216	308	560	2.7	233	327	6.9	674	2.9	288	386
	80-84	363	1.9	155	208	398	1.9	171	227	9.6	477	2.1	207	270
	85+	256	1.3	85	171	287	1.4	95	192	12.1	387	1.7	127	260
	MEDIAN AGE	33.6		33.1	34.2	34.2		33.7	34.8		35.9		35.4	36.5

INCOME CHARACTERISTICS

		1979		1989		1992		1997		%CHNG
COUNTY	HOUSEHOLD INCOME ($)	NUMBER	%	NUMBER	%	NUMBER	%	NUMBER	%	89-92
WARREN	UNDER 15,000	2,395	46.6	1,863	26.4	1,750	23.5	1,650	19.7	-6.1
	15,000-29,999	1,835	35.7	1,782	25.2	1,877	25.2	2,170	25.9	5.3
	30,000-49,999	748	14.5	2,160	30.6	2,270	30.5	2,326	27.7	5.1
	50,000-74,999	111	2.2	1,016	14.4	1,148	15.4	1,545	18.4	13.0
	75,000 & ABOVE	52	1.0	249	3.5	392	5.3	698	8.3	57.4
	MEDIAN HHOLD INC	16,108		29,028		30,700		33,431		5.8
	AVERAGE HHOLD INC	19,438		32,149		35,203		40,664		9.5
	PER CAPITA INCOME	6,793		11,688		12,815		14,962		9.6
	MEDIAN FAMILY INCOME	18,986		33,773		35,864		40,039		6.2

FIGURE 5c

MISSOURI
LINCOLN COUNTY (113)

CENSUS, ESTIMATED AND PROJECTED DATA - 1992 DATA
HOSPITAL INDUSTRY DATA INSTITUTE

POPULATION CHARACTERISTICS	1980 CENSUS	1990 CENSUS	1992 ESTIMATE	1997 PROJECTED	%CHNG 90-92
POPULATION	22,193	28,892	30,354	33,946	5.06
PCT OVER 65	14.67	11.48	11.70	12.07	1.87
HOUSEHOLDS	7,638	10,316	10,827	12,170	4.95
POP/HOUSEHOLD	2.85	2.77	2.77	2.75	0.09
FAMILIES	6,043	7,913	8,209	8,984	3.74
HOUSING UNITS	9,657	12,284	12,866	14,428	4.74
POP GRP QTRS	402	353	374	426	5.95

POPULATION BY AGE AND SEX

		1990 CENSUS				1992 ESTIMATE				%CHNG	1997 PROJECTED			
COUNTY	AGE	TOTAL	%	MALE	FEMALE	TOTAL	%	MALE	FEMALE	90-92	TOTAL	%	MALE	FEMALE
LINCOLN	0- 4	2,444	8.5	1,245	1,199	2,613	8.6	1,332	1,281	6.9	2,772	8.2	1,413	1,359
	5- 9	2,644	9.2	1,400	1,244	2,747	9.0	1,455	1,292	3.9	3,107	9.2	1,646	1,461
	10-14	2,368	8.2	1,241	1,127	2,541	8.4	1,331	1,210	7.3	2,851	8.4	1,493	1,358
	15-17	1,220	4.2	642	578	1,215	4.0	641	574	-0.4	1,424	4.2	750	674
	18-20	1,005	3.5	494	511	1,010	3.3	498	512	0.5	1,109	3.3	545	564
	21-24	1,317	4.6	638	679	1,345	4.4	653	692	2.1	1,287	3.8	625	662
	25-29	2,439	8.4	1,205	1,234	2,348	7.7	1,158	1,190	-3.7	2,314	6.8	1,140	1,174
	30-34	2,622	9.1	1,333	1,289	2,724	9.0	1,385	1,339	3.9	2,658	7.8	1,350	1,308
	35-39	2,244	7.8	1,121	1,123	2,419	8.0	1,211	1,208	7.8	2,728	8.0	1,371	1,357
	40-44	1,865	6.5	950	915	2,028	6.7	1,036	992	8.7	2,451	7.2	1,260	1,191
	45-49	1,694	5.9	877	817	1,927	6.3	994	933	13.8	2,445	7.2	1,265	1,180
	50-54	1,347	4.7	703	644	1,480	4.9	771	709	9.9	2,006	5.9	1,041	965
	55-59	1,241	4.3	634	607	1,274	4.2	653	621	2.7	1,539	4.5	790	749
	60-64	1,125	3.9	573	552	1,133	3.7	580	553	0.7	1,159	3.4	598	561
	65-69	983	3.4	455	528	999	3.3	462	537	1.6	1,031	3.0	487	544
	70-74	840	2.9	368	472	918	3.0	405	513	9.3	1,020	3.0	453	567
	75-79	709	2.5	299	410	760	2.5	324	436	7.2	919	2.7	403	516
	80-84	425	1.5	142	283	468	1.5	159	309	10.1	571	1.7	201	370
	85+	360	1.2	96	264	405	1.3	108	297	12.5	555	1.6	153	402
	MEDIAN AGE	31.9		31.3	32.6	32.5		31.8	33.2		34.0		33.3	34.7

INCOME CHARACTERISTICS

		1979		1989		1992		1997		%CHNG
COUNTY	HOUSEHOLD INCOME ($)	NUMBER	%	NUMBER	%	NUMBER	%	NUMBER	%	89-92
LINCOLN	UNDER 15,000	3,677	48.1	2,590	25.1	2,438	22.5	2,344	19.3	-5.9
	15,000-29,999	2,864	37.5	2,861	27.7	2,941	27.2	2,930	24.1	2.8
	30,000-49,999	948	12.4	3,192	30.9	3,312	30.6	3,412	28.0	3.8
	50,000-74,999	101	1.3	1,327	12.9	1,521	14.0	2,376	19.5	14.6
	75,000 & ABOVE	48	0.6	346	3.4	615	5.7	1,108	9.1	77.7
	MEDIAN HHOLD INC	15,547		28,004		30,195		33,822		7.8
	AVERAGE HHOLD INC	17,645		31,230		34,705		41,252		11.1
	PER CAPITA INCOME	6,120		11,183		12,410		14,823		11.0
	MEDIAN FAMILY INCOME	18,122		32,435		34,852		39,497		7.5

FIGURE 5d

MISSOURI
PIKE COUNTY (163)

CENSUS, ESTIMATED AND PROJECTED DATA - 1992 DATA
HOSPITAL INDUSTRY DATA INSTITUTE

POPULATION CHARACTERISTICS	1980 CENSUS	1990 CENSUS	1992 ESTIMATE	1997 PROJECTED	%CHNG 90-92
POPULATION	17,568	15,969	15,728	15,099	-1.51
PCT OVER 65	16.06	17.27	17.42	17.70	0.87
HOUSEHOLDS	6,297	6,083	6,028	5,908	-0.90
POP/HOUSEHOLD	2.74	2.57	2.55	2.50	-0.64
FAMILIES	4,710	4,380	4,290	4,094	-2.05
HOUSING UNITS	7,389	7,128	7,049	6,893	-1.11
POP GRP QTRS	306	340	339	330	-0.29

POPULATION BY AGE AND SEX

		1990 CENSUS				1992 ESTIMATE				1997 PROJECTED			
COUNTY	AGE	TOTAL	%	MALE	FEMALE	TOTAL	%	MALE	FEMALE	%CHNG 90-92	TOTAL	%	MALE	FEMALE
PIKE	0- 4	1,134	7.1	581	553	1,134	7.2	581	553	0.0	1,023	6.8	525	498
	5- 9	1,238	7.8	617	621	1,207	7.7	602	605	-2.5	1,168	7.7	583	585
	10-14	1,278	8.0	662	616	1,283	8.2	665	618	0.4	1,233	8.2	639	594
	15-17	706	4.4	385	321	661	4.2	360	301	-6.4	657	4.4	357	300
	18-20	584	3.7	305	279	552	3.5	289	263	-5.5	522	3.5	274	248
	21-24	649	4.1	342	307	624	4.0	329	295	-3.9	511	3.4	270	241
	25-29	1,048	6.6	497	551	952	6.1	451	501	-9.2	796	5.3	377	419
	30-34	1,138	7.1	573	565	1,106	7.0	557	549	-2.8	920	6.1	463	457
	35-39	1,041	6.5	515	526	1,054	6.7	523	531	1.2	1,020	6.8	508	512
	40-44	1,012	6.3	484	528	1,029	6.5	494	535	1.7	1,066	7.1	516	550
	45-49	940	5.9	455	485	993	6.3	482	511	5.6	1,083	7.2	530	553
	50-54	816	5.1	388	428	833	5.3	395	438	2.1	947	6.3	454	493
	55-59	838	5.2	423	415	807	5.1	408	399	-3.7	821	5.4	415	406
	60-64	789	4.9	401	388	753	4.8	385	368	-4.6	660	4.4	341	319
	65-69	834	5.2	377	457	799	5.1	360	439	-4.2	718	4.8	329	389
	70-74	646	4.0	267	379	656	4.2	273	383	1.5	625	4.1	262	363
	75-79	536	3.4	226	310	534	3.4	227	307	-0.4	544	3.6	236	308
	80-84	406	2.5	122	284	410	2.6	124	286	1.0	413	2.7	129	284
	85+	336	2.1	97	239	341	2.2	98	243	1.5	372	2.5	109	263
	MEDIAN AGE	36.0		34.1	38.0	36.6		34.7	38.6		38.5		36.7	40.3

INCOME CHARACTERISTICS

		1979		1989		1992		1997		%CHNG
COUNTY	HOUSEHOLD INCOME ($)	NUMBER	%	NUMBER	%	NUMBER	%	NUMBER	%	89-92
PIKE	UNDER 15,000	3,578	56.8	2,151	35.4	1,951	32.4	1,710	28.9	-9.3
	15,000-29,999	2,013	32.0	1,906	31.3	1,910	31.7	1,833	31.0	0.2
	30,000-49,999	490	7.8	1,379	22.7	1,437	23.8	1,478	25.0	4.2
	50,000-74,999	144	2.3	470	7.7	548	9.1	655	11.1	16.6
	75,000 & ABOVE	72	1.1	177	2.9	182	3.0	232	3.9	2.8
	MEDIAN HHOLD INC	12,978		21,195		22,350		24,624		5.4
	AVERAGE HHOLD INC	16,850		25,788		27,936		31,370		8.3
	PER CAPITA INCOME	6,063		9,919		10,771		12,352		8.6
	MEDIAN FAMILY INCOME	15,943		26,066		27,414		30,267		5.2

Mental Health Problems of the Elderly

According to Butler, a noted psychiatrist and a pioneer in geriatric medicine, as the number of older people in the United States increases, so does the demand for geriatric mental health care. (Butler, 1991). Along with this growth, more elderly are expected to be referred and admitted to the general psychiatric hospital because more and more elderly are using psychiatric mental health services (Tillman-Jones, 1990).

It is estimated by mental health experts and providers that 18%-25% of older people suffer from symptoms of mental illness (Butler, 1990). Gaitz and Varner (1982) in their article on principles of mental health care of elderly patients stated that the elderly suffer from the same mental health problems as the young, but the risk of disturbance due to multiple losses is greater. For example, the loss of work and the decline in social status which often accompanies the loss of employment are two of the major causes of mental stress in the elderly. In a work-oriented society, these losses can very easily lead to feelings of uselessness and lack of self-worth. If these feelings are not replaced with something meaningful to the individual, this sense of worthlessness can and will develop into depression.

A study conducted by the National Institute of Mental Health (NIMH) discovered that the two major mental health problems among the elderly were depression and cognitive impairment, which was frequently associated with Alzheimer's disease (1988). In addition, the elderly suffer from a variety of other mental health problems, including anxiety, alcoholism and schizophrenia. For the purpose of this paper, however, depression and cognitive impairment will be the focused topics.

Depression is the most common of the emotional disorders found in the elderly and can occur at any time in one's life (Hogstel, 1990). Depression may vary from the ordinary "blues" that everyone experiences to the more serious condition which results in extreme withdrawal and/or suicide.

Loss of a loved one and the resulting isolation is a major cause of depression and suicide for the elderly according to The National Center for Health statistics. "The first year after the death of a spouse, the risk of suicide for the remaining partner is 2.5 times greater than in the general population; in the second year after a loss, the risk is 1.5 times as great" (Information Plus, 1990, p. 60).

To further emphasize the impact of suicide among the elderly, one out of every four suicides are committed by people over 65. One-

half of elderly suicides are committed by persons who live alone. "In 1986, the average suicide rate for persons 65 to 74 years was 19.7 per 100,000 population. Those 75 to 84, the rate was even higher - 25.2 per 100,000" (Information Plus, 1990, p. 60). "The suicide rate among males is greater than that of females and males who are 80+ years of age are at particular risk" (Figure 6, Butler, 1991, p. 129).

Suicide then becomes a significant threat to this ever increasing aging population as "one in six elderly depressions succeed in committing suicide in contrast to 1 in 100 in the general population" (Information Plus, 1990, p. 60).

FIGURE 6

Number of suicides per 100,000 population by age and sex in 1986 San Diego suicide study.

AGE	MALE	FEMALE
15 - 24	11.9	4.8
25 - 44	25.7	8.2
45 - 64	29.3	13.6
65 +	31.9	15.9
Overall	18.2	7.9

Rich et al. (1986). San Diego Suicide Study. Archives of General Psychiatry 43:577-82.

The deterioration of the mind, or cognitive impairment as it is clinically referred to, is another psychiatric symptom suffered by the elderly. Twenty-five percent of the older population in general and 70% to 90% of older people in nursing homes suffer from cognitive impairment (Heacock, Walton, Beck & Mercer, 1991). Cognitive impairment is defined as a disruption in brain functions. It involves the deterioration of the intellectual functions including the capacity to acquire, process, classify, integrate, store and recall information. In addition, cognitive impairment includes the inability to communicate or act on information, the inability to think and learn, forgetfulness and the loss of a sense of time and place. The most significant impairment then becomes one's inability to perform activities of daily living (those activities required to care for oneself - bathing, eating, toileting, dressing, and getting in/out of bed) (Heacock et al, 1991, Butler, 1991). These symptoms combined become the mental disorder of Dementia. The most prevalent form of dementia is Alzheimers disease named after the German neurologist Alois Alzheimer, who in 1906, discovered the "neurofibrillary tangles" now associated with the disease.

Alzheimer's disease has been identified as the fourth leading cause of death in the United States. A 1989 survey by researchers at Bringham Young Women's Hospital, the most comprehensive study of

prevalence to date, indicates that as many as 10.3 percent of all people over the age of 65 with memory problems or other mental impairment probably suffer from Alzheimer's disease. The study indicates that up to 3 percent of people between 65 and 74, 18.7 percent of those between 75 and 84, and 47.2 percent of those over 85 may have the disease. "According to the National Institute on Aging there may be 4 million Alzheimer victims in the United States today and by 2050 the number may reach 14 million" (Information Plus, 1990, p. 55).

With the increase of aging population there will be a parallel increase in elderly persons with mental disorders including dementia, Alzheimer's disease, anxiety or alcoholism. Each community will need to take an active role in providing a variety of services for the elderly's needs, or prepare for a relocation of this population to those communities which have invested to develop very particular health care services. In the St. Louis network of hospital-based health care providers, the need to provide inpatient geropsychiatric services has already been addressed by the formation of at least six units specifically designated as geropsychiatric treatment centers.

In St. Charles, Warren, Lincoln and Pike Counties there are no geropsychiatric inpatient service treatment centers for the elderly population. Physicians in these counties have the option of referring

their elderly patients either to general medical units in their local hospitals, to the general psychiatric unit at St. Joseph Health Center or to St. Louis County for specialized geropsychiatric services.

The Interface of Mental Illness and Physical Health Problems Among the Elderly

When treating the elderly for mental health problems, it is important that the physical problems of the elderly are appropriately assessed. Robert R. Butler, a noted psychiatrist in the geriatric field, states that depression in the elderly is usually coupled with some sort of medical condition. He lists the following as common medical conditions associated with depression in the elderly:

Medical Conditions Commonly Associated With Depression in the Elderly

Coronary Artery Disease
: Hypertension, myocardial infarction, coronary artery bypass surgery, congestive heart failure.

Neurologic Disorders
: Cerebrovascular accidents, Alzheimer's disease. Parkinson's disease, amyotrophic lateral sclerosis, multiple sclerosis, Binswanger's disease.

Metabolic Disturbances

Diabetes mellitus, hypothyroidism, hyperthyroidism, hypercortisolism, hyperparathyroidism, Addison's disease, autoimmune thyroiditis.

Cancer

Pancreatic, breast, lung, colonic, and ovarian carcinoma; lymphoma, and undetected cerebral metastasis.

Other Conditions

Chronic obstructive pulmonary disease, rheumatoid arthritis, deafness, chronic pain, sexual dysfunction, renal dialysis, chronic constipation.

(Butler, 1991 page 127).

Along with Butler, Mildred Hogstel, a geropsychiatric nurse, in her book, Geropsychiatric Nursing (1991) further emphasizes the prevalence of physical problems being interfaced with mental problems when treating the elderly. She lists the following as areas of concern:

1. Physical health problems, including fecal impaction, dehydration, severe pain, hypothermia, infection, and electrolyte disturbance may cause confusion, depression, and cognitive impairment.

2. Psychiatric factors precipitate physical health problems (e.g. depression may create weight loss, dehydration, electrolyte disturbance).

3. Psychosocial factors influence the course of a medical disorder (e.g. living alone and/or never being married might precipitate nursing home placement after the amputation of the right leg of a 90-year-old man); bereavement and emotional factors have been associated with the body's

ability to fight off infections, thus resulting in increased hospitalizations.

4. Concurrent mental and physical health problems influence the course of one another (e.g. a paranoid state and congestive heart failure might make a patient think his prescribed medicines are poisons. The resulting paranoia might ultimately interfere with the proper medical management for congestive heart failure).

5. Mental or physical health problems that result from the toxic side effects of drugs, such as digitalis, corticosteroids, anti diabetic agents, anti hypertensive agents, and tricyclic anti depressants may all produce delirious states of disorientation, memory loss, confusion, and personality changes. Several studies indicate that up to 25% of admissions of individuals 65 and older to health care facilities are caused by drug-drug or drug-food interactions. (Hogstel, 1990, page 7).

In conclusion, the elderly who suffer from psychological problems for which they need care may also suffer from multiple chronic medical problems that must be addressed. Hogstel notes that 50% of the emergency room admissions for psychiatric problems of the elderly have an underlying medical (organic) cause. In an out-patient population, from 20% to 40% of patients with psychiatric symptoms have medical problems that cause or contribute to their mental state. (Pies, 1987).

Treatment for the Elderly

In the course of this paper it has been established that the elderly population will be dramatically increasing. Their need for mental and physical health services will also increase at a substantial rate. Where will these elderly be served and by whom?

Five percent of the elderly reside in nursing homes and the remaining ninety five percent live within their own community (Hogstel, 1990). The various physicians of these elderly will determine the source of their treatment -- whether by a community mental health counseling center, their own personal medical physician, a general psychiatrist, or a psychiatrist who specializes in the mental health care of the elderly.

Geropsychiatry is a relatively new area of specialization in the rapidly expanding field of treatment for the elderly. The term geropsychiatry refers to the study, diagnosis and prevention of mental illness in the elderly. Treatment for the mentally ill elderly as a sub-specialty began in the early 1900's, but significant interest in the field of geropsychiatry has grown rapidly in the last 10-15 years (Hogstel, 1990). This increased interest can be attributed to the ever increasing growth of the elderly as a specific population. The American Psychiatric Association, in 1986, listed 2,000 of it's 35,000 members who

primarily focused on geriatric patients and an additional 5,000 members reported that geriatric psychiatry comprised most of their practices (Butler, 1991).

Current literature regarding geropsychiatry reveals that only in the last 15 years has psychiatry focused on treating the elderly patients in an acute hospital setting (Billig, 1987). Although there has been an awareness of the special problems associated with aging and an awareness of the increasing number of elderly, providing specialized services in a hospital setting has fallen far behind mental health services for other segments of the population. Reluctance on the part of the psychiatrist to admit the elderly for treatment seems to account for less elderly admissions.

Butler notes that psychiatrists only in the 1980's began to recognize the growing need to treat the elderly. A study in 1979 indicated the pessimism psychiatrists had regarding treatment of the elderly and can possibly account for the many negative attitudes established concerning treatment. The study revealed that:

1. Psychiatrists regarded older patients as less ideal to work with than younger patients with identified symptoms.
2. The prognosis for older persons was considered poorer than that for young persons, even though the data

(admittedly limited) on the prognosis of older persons do not support this conclusion.

3. Psychiatrists were much less likely to use psychotherapy, especially with older depressed women, than they were with younger persons (those 65-74 years old). Instead they gave drugs, with the implication that psychotherapy would not be worthwhile (Butler, 1991, page 248-249).

In addition to limited psychiatric care being given to the elderly by psychiatrists, the American Geriatrics Society stated in 1987 that community surveys completed suggested that only 1 percent or fewer of the elderly receive psychiatric care. Only 4 percent of community mental health center patients are over 65 years of age, fewer than 4 percent of patients seen by private practitioners are elderly and less than 1.5 percent of all community based mental health care goes to the older population (American Geriatric Society Public Policy Committee, 1988). Therefore, not only were the elderly being slighted by the medical profession, but the community in which they lived offered limited services to them. These small percentages suggest a significant discrepancy when considering that 8 million of the more than 26 million people over the age of 65 years in the United States are thought to suffer from some form of psychiatric disorder (Butler, 1991).

German, Shapiro, Skinner, VonKorff, Klein, Turner, Teitelbaum, Burka, & Burns, (1987) suggested in their article in the Journal of the American Medical Association that there exists another reason for limited mental health services to the elderly. The stigma that the elderly who have been associated with a particular mental illness might be "morally weak" and should be kept away from the rest of society, causing them to become outcasts. Moreover, as Whall and Conklin (1985) state, "it is necessary to recognize that the elderly are reluctant to seek treatment because this is the age group that remembers asylums of the past" (p. 24). Barriers such as these affect if and when the elderly receive treatment.

Butler states that it is more than psychiatrist reluctance to treat the elderly, or stigmas attached to mental illness. There is the general negative attitude toward the elderly that he describes as ageism - the prejudices and stereotypes that are applied to older people sheerly on the basis of their age (Butler, 1991). In 1971, over 20 years ago, the Group for the Advancement of Psychiatry issued a report, "The Aged and Community Mental Health," which listed some of the major reasons for negative attitudes toward the elderly. They are as follows:

1. The aged stimulate the therapist's fears about his (her) own old age.

2. They arouse the therapist's conflicts about his (her) relationship with parental figures.

3. The therapists believes he (she) has nothing useful to offer older people because he (she) believes they cannot change their behavior or that their problems are all due to untreatable organic brain diseases.

4. The therapist believes that his (her) psychodynamic skills will be wasted if he (she) works with the aged, since they are near death and not really deserving of attention (similar to the triage system of the military, in which the sickest receive the least attention because they are least likely to recover).

5. The patient might die while in treatment, which could challenge the therapist's sense of importance.

6. The therapist's colleagues may be contemptuous of his (her) efforts on behalf of aged patients. (One often hears the remark that gerontologists or geriatric specialists have a morbid preoccupation with death; their interest in older persons is therefore "sick" or suspect.) (Butler, pp. 243 - 244).

To resolve the dilemma of providing needed psychiatric services to the elderly and to overcome the numerous barriers to treatment, a specialized geropsychiatric unit is an excellent solution. This type of facility would also integrate the delivery of physical health services and mental health services in an environment that is conducive to the positive self-feelings of the elderly. In this type of treatment unit the

elderly are provided with an age-based peer group who are served by physicians that are committed to the treatment of the elderly and a multi-disciplinary treatment staff who have been specifically prepared to serve the elderly.

CHAPTER III

Methodology

In an effort to provide supportive data for a geropsychiatric unit proposal a survey was conducted of four major hospitals in the St. Louis network. A questionnaire (Appendix A) was developed and an interview was scheduled with a representative of each health care facility to determine the types of staff servicing the elderly, number of patients who can be served, programming provided, discharge planning procedures, referral sources utilized, etc. The survey discovered that of these four health care providers, all four have already developed geropsychiatric units and are promoting them as an integral component of their overall psychiatric continuum of care.

Hospitals Selected

The four hospitals chosen represented four major health care providers who were in close proximity to the area served by St. Joseph Health Center - St. Joseph Hospital West.

DePaul Hospital, the closest hospital to St. Joseph Health Center located in Bridgeton, Missouri is a hospital offering psychiatric services to adults, adolescents and chemically dependent. DePaul has

their own geropsychiatric unit separate from other psychiatric units for those patients over the age of 65 or patients who meet admission criteria.

Barnes - St. Peters Hospital located in St. Peters, Missouri (in St. Charles County) does not have a geropsychiatric unit. However, geriatric patients are referred to the geropsychiatric unit at Barnes Hospital in St. Louis County. It should be noted that the survey does not include an interview with Barnes Hospital.

Christian Hospital Northwest, located in north St. Louis County, offers psychiatric services to all ages and in 1993 opened their geropsychiatric unit separate from the other psychiatric units.

St. Anthonys Psychiatric Center located in West St. Louis County also offers a separate geropsychiatric unit for elderly patients.

Interviews

Interviews were held with a social worker at DePaul, a nurse manager at Barnes - St. Peters, a Director of Activity Therapy at Christian Northwest and the Program Director of psychiatric services at St. Anthonys Psychiatric Center. On-site interviews and tours were conducted at DePaul Hospital and St. Anthonys Psychiatric Center;

interviews for Barnes-St. Peters and Christian Hospital Northwest were conducted over the phone.

CHAPTER IV

Results of the Survey

Results of the survey revealed that each of the four hospitals have a separate geropsychiatric unit available to their patients who are elderly and in need of psychiatric care. The hospitals interviewed further provided information that they maintain a daily average of twelve patients and that these patients stay in the hospital an average of eleven days. The main diagnoses these units have seen are depression and dementia/Alzheimers disease with an average age of 66 years. Most referrals come from nursing homes and most reimbursement is through Medicare.

The units are professionally staffed with registered nurses, social workers, activity therapists, and in some cases, a medical director and psychologist. All units provide care with an inter-disciplinary treatment approach. All four hospitals utilize as an assessment tool, the Mini-Mental State by Folstein, Folstein, and McHugh (1975), a standardized cognitive assessment that focuses on the cognitive aspects of mental functions. Additional assessments used included the Short Blend Test and the Geriatric Depression Scale. Programs provided for these special units included medication instruction, activities of daily living and reorientation by nursing personnel and group therapy provided by

psychologists. Activity therapy programs included music, reality orientation, reminiscing therapy groups, exercise, current events and pet therapy, provided by recreation therapists and in some cases music therapists. Social workers were found to provide support therapy to the patient and their families and aided in the critical area of discharge planning. All of the hospitals value staff education as an essential component to caring for the geriatric patient, and each participate in providing continued education for their staff.

It is important to note that when each representative was asked "Why have you separated your elderly patients from the rest of the psychiatric population?" the following responses were given.

From DePaul Hospital: "For safety reasons"; "this population needs special assistance with walking, activities of daily living and other areas of physical assistance and there was a need to separate them from the more active, ambulatory, younger acting out (more physically threatening) patients on the psychiatric unit."

St. Anthonys Psychiatric Center responded: "This population of patients (meaning the elderly) has significantly increased in admissions over the past five years and we needed space specifically allocated for treatment of the problems generic to the elderly population."

Christian Northwest emphasized that: "This population of elderly usually have several medical problems along with psychiatric problems; it was recognized that we needed a special unit with trained staff who had a genuine interest in caring particularly for the elderly's physical and psychiatric problems."

The following chart depicts the information summarized from the questionnaire.

SURVEY RESULTS

	DePaul	St. Anthonys	Christian N.W.
History of the Geropsychiatric Unit			
* How long has the unit been in existence?	5 years	2 years	8 months
* Is the unit locked or unlocked?	† Unlocked	Locked	Locked
* How many beds?	20	15	10
Admission Criteria			
* Average Age?	62	69	69
* Diagnosis?			
• Alzheimers/ Dementia	60%	50%	50%
• Depression	20%	50%	50%
• Alcoholism	10%		
• Schizophrenia	10%		
Referrals			
* Physician	X		X
* Nursing Home	X	X	X
* Family	X		X
Average Length of Stay	10 days	17 days	9 days
Average Daily Census	12 patients	12 patients	10 patients
Assessments (standardized)			
* Mini-Mental Exam	X	X	X
* Short Blessed Test		X	
* Geriatric Depression Scale		X	

† Unlocked - this unit can be locked.

(Survey Continued)	DePaul	St. Anthonys	Christian N.W.
Reimbursement			
* Medicare	90%	90%	90%
* Medicaid	1%	1%	1%
* Other	9%	9%	9%
Discharge Planning			
* Aftercare Program	Yes - once a month	No	Yes
Staffing			
* Medical Director	Yes	No	No
* ActivityTherapist/Music Therapist	Rec. Therapist	Music & Rec. Therapist	Rec. Therapist & Oct. Therapist
* Social Worker	Yes	Yes	Yes
* Nursing	Yes	Yes	Yes
* Mental Health Counselor	Yes	---	---
* Psychologist	---	Yes	---
Do you use the multi disciplinary approach to treatment?	Yes	Yes	Yes
How often do you meet?	2 times/ week	1 time/ week	3 times/ week
Program			
* Activity Therapy			
• Exercise	X	X	X
• Music	X	X	X
• Reminisce	X		
• Recreation/Constructive Leisure	X	X	X
• Current Events			X
• Grooming			X
• Pet Therapy		X	

(Survey Continued)	DePaul	St. Anthonys	Christian N.W.
Nursing			
* Medication Teaching	X	X	X
* Reality Orientation	X	-	X
Psychologist			
* Group Therapy		X	
Social Worker (MSW/LCSW)			
* Group Therapy	X		X
Mental Health Counselor			
* Educational Groups	X		
Are you DRG exempt?	X	X	X
Staff Education			
* Ongoing inservices, workshops and seminars	X	X	X
* Ongoing Education Task Force twice monthly with a geriatric consultant		X	

In summary, there are multiple reasons for establishing a geropsychiatric unit. As specified by those hospitals included in the survey the commitment to build was premised upon both a reflection of existing documentation of patients needing such services and the projection that the need would be expanding significantly in following years, thereby providing a strong base for such a commitment and investment.

St. Charles county has not developed a specialized treatment unit for it's elderly population who suffer from psychiatric illness. Such a unit has not been developed in the immediate surrounding area of Lincoln, Warren and Pike counties and, in fact, such a unit does not exist in a large number of the rural counties to the North and West of St. Charles county. The demographics of these counties show an increasingly elderly population that is voicing a concern for mental health services and expanded medical services.

Who is to serve this population? Who is to fill this obvious gap in services? If not the dominant medical provider in this region, the St. Joseph Health Center, then, would it be prudent to invite another major vendor from St. Louis county to expand into this catchment area?

CHAPTER V

Conclusion

St. Joseph Health Center, the leading health care provider in St. Charles, Warren, Lincoln and Pike counties, is second to no-one in providing psychiatric care to those in need of mental health services. Their psychiatric program began almost 20 years ago with only eighteen beds. Those eighteen patients were adult patients with psychiatric problems, the elderly, the alcohol/drug abuser and at some times an adolescent patient. All of these patients were serviced on one locked (or closed) unit. Through the years there was a need to create additional psychiatric beds because of the increase in admissions of those patients who were experiencing stress and/or situational crisis. This opened up what was called the "Open Psychiatric Unit" and in the past eight years it has been known as the "Stress Unit." This additional unit provided 30 more beds for psychiatric services.

Along with the additional need to care for patients suffering from depression and stress-provoked illnesses, a need arose to extend specialized psychiatric services to the alcohol and drug abuser. A chemically dependent unit was contracted to open and did so, serving the adult and adolescent chemically dependent patient.

In the last five years, the St. Joseph Health Center has also extended its healing ministry to the mentally ill adolescent patient by opening an eighteen bed unit. With the dissolution of the contracted chemically dependent program, St. Joseph Health Center - St. Joseph Hospital West opened the "SSM Recovery Unit" for adult chemically dependent patients at St. Joseph Hospital West in Lake St. Louis.

The philosophy of the SSM Health Care System states, "we strive to change with the times and serve those who are in greatest need." It is now the time to expand and serve more thoroughly yet another segment of our population who are urgently in need of mental health services -- the elderly.

As mentioned earlier in this paper, the elderly are the fastest growing segment of our population and as the Hospital Industry Data indicated (Figure 5, a, b, c, d), the counties of St. Charles, Warren, Lincoln and Pike, as a group, will increase in elderly population by 51% by 1997.

In addition, the following data was collected from admission reports at St. Joseph Health Center during the calendar year January 1, 1992 to December 30, 1992 and clearly identifies the emphasis for services to the elderly.

TOTAL ADMISSIONS TO ADULT PSYCHIATRY - 806

TOTAL ADMISSIONS TO ADULT PSYCHIATRY OVER THE AGE OF 60 - 186

23% OF ADMISSIONS WERE OVER 60 YEARS OF AGE

AGE:	TOTAL	%
60 - 69 years	73	39%
70 - 79 years	80	43%
80 + years	33	18%
GENDER:		
Males	56	30%
Females	130	70%

REIMBURSEMENT:	TOTAL	%
Medicare A & B with Medicaid	21	11%
Commercial and/or Service Ins.	14	8%
Medicare A & B	144	77%
Blue Cross	4	2%
Medicare A with Medicaid	1	.05%
No Insurance	2	1%

Average Length of Stay

Total Days of Treatment, patients aged 60+ = 3,024 days
Average Length of Stay = 16 days

Diagnoses (Principle ICD - 9-CM Diagnosis)

	TOTAL	%
Schizophrenia Disorder	17	9%
Dementia (Senile, Organic Brain Syndrome)	45	24%
Affective Disorder (Depression, Manic Depressive)	112	60%
Personality Disorders (Alcoholism)	5	3%

The above data strongly emphasizes the need for St. Joseph Health Center to consider the urgency for specialized psychiatric treatment for its elderly patients needing mental health services. When combined with the demographics of their catchment area (Figure 5. a, b, c, d) this data strongly endorses a commitment by St. Joseph Health Center - St. Joseph Hospital West to develop a geropsychiatric treatment unit.

This paper is not intending to promote the development of a specialized treatment program that is without precedent or previously untried. The survey clearly documents that such treatment centers already exist in the St. Louis Metro area and they have been a highly successful alternative for treating the mental health problems of the elderly. The purpose of this paper is to support the development of a geropsychiatric treatment unit as an "add-on" service to the existing compliment of services at St. Joseph Health Center - St. Joseph Hospital West.

Proposal

The graying of America is upon us. The elderly are present in large numbers in the U.S. population and their number continues to increase. Psychiatric services for the elderly, unfortunately, are inadequate and have not received the same attention as medical services for this population (Whall & Conklin, 1985). Data that has already been gathered clearly indicates the prominence of the elderly population receiving mental health services at St. Joseph Health Center and even the simplest projection supports the premise that the elderly in need of psychiatric services will continue to be a primary part of the hospital's admission statistics.

It has already become evident that St. Joseph serves a larger than average number of elderly patients. Consequently, the Health Center must continuously seek cost-effective, efficient treatment mechanisms to treat the many physical problems of the aging group and to serve both acute and chronic conditions that affect the elderly.

An inpatient geropsychiatric unit at St. Joseph Health Center is an excellent vehicle for delivering comprehensive evaluations and psychiatric treatment to the elderly. The increasing number of elderly patients coupled with the cost-based reimbursement for psychiatric services, can result in a continued demand for geropsychiatric services

at St. Joseph Health Center. The purpose of this paper is to collect data regarding the continuing unmet needs of the elderly in St. Charles, Warren, Lincoln and Pike counties. The conclusion of this data might serve to justify the commitment of finances and other resources for the establishment of geropsychiatric services at St. Joseph Health Center - St. Joseph Hospital West.

Scope

Typically, inpatient geropsychiatric units provide evaluation and treatment services to patients with emotional, cognitive and behavioral symptoms associated with aging. Two such conditions are dementia and depression, which have both acute and chronic phases and affect an increasing number of patients each year.

Diagnosis of dementia and other psychiatric illnesses has become a more exact science recently, with the more advanced technology assessments and evaluations conducted such as MRI, EEG, BEAM, etc. As well as technology, assessment and evaluation conducted by a multidisciplinary team (including physician, nurse, social worker and other specialists) have been determined to be effective methods of identifying the presence of psychiatric illness. Through these means, a definitive diagnosis can be reached, a plan of treatment

and/or case developed, and families counseled about the future of their loved one. Patients are evaluated by a multidisciplinary team with individualized treatment plans developed to promote the patient's maximum functional level and to assist the family in making decisions for future care. A multi-disciplinary approach to treatment is essential because of the multiple physical conditions that are usually coupled with the psychiatric illness (Butler, 1991). It is not uncommon for a patient to have congestive heart failure, osteoarthritis, and hypertension, along with depression. The staff needed to assist this elderly patient include: a clinical nurse specialist, consulting internist, a clinical pharmacist, recreational therapists, social worker and a psychiatrist. A multi-disciplinary team approach has the benefit of providing a wide range of focus to more aggressively serve the patients' needs (Whall & Conklin, 1989).

Services

Services provided on an inpatient geropsychiatric unit include the following:

1. Multi-disciplinary evaluation/assessment (must include psychiatrist, medical consult, nursing, social work, activity

therapy, speech, hearing, vision, dental, pharmacy, dietary);

2. Primary-care nursing;
3. Individual, group and family therapy;
4. Recreational/music therapy;
5. Occupational and physical therapy;
6. Reminiscence and reality orientation;
7. Pharmacologic therapy and education;
8. Religious/spiritual services;
9. Comprehensive discharge planning;
10. Speech and hearing therapy;
11. Other diagnostic procedures as prescribed.

It is critical to have appropriate medical back-up and to incorporate this back-up into the team approach (Ford, 1980). Also, continuing education of staff is an essential component of this type of programming, to maintain their motivation to work with the elderly and improve their skill levels for this population.

Structural and Environmental Requirements

Whall & Conklin (1985) identify that structurally, the geropsychiatric unit needs to be different. The hallways need to be

skid proof and well lighted. Glare causes confusion; therefore, indirect lighting is best. Carpeting of the unit may be helpful, and if bathrooms are well located and plentiful, upkeep is usually not too much of a problem. Carpeting without tremendous thickness facilitates wheelchair usage. Geometric patterns are not good for floor coverings, however, as these sometimes resemble up-and-down steps to those with visual problems.

The rooms and bathrooms need to have doorways wide enough for wheelchairs and in certain instances toilet stools need risers so that they are tall enough for a wheelchair transfer. Floor placement of the feet is an important element for orientation while the elderly person is on a toilet stool; foot stools may be needed to accomplish this. Special tubs that are high enough so that persons can sit at a higher level than usual facilitates getting in and out of the tub.

It is well known that the colors used on the wards are important. For example, a true red, a clear rust, and/or medium tan, are usually easily discerned by the elderly (Conklin, 1981). Muted colors, such as blue-greys and blue-greens are difficult to distinguish. Color coded doors and matching rooms help the elderly identify the correct room, and names on doors in bold lettering not only help to

distinguish the rooms, but make the hospital more personal. Bathroom doors need to be distinctively marked.

Private rooms seem to help with maintaining orientation: waking up in the middle of the night with a strange roommate can be distressing. A nursing history will determine in what direction the patient walked to go to the bathroom from their bed at home. The room can be arranged in this general configuration so as to ally nighttime confusion. Increased nighttime voiding needs make this a necessary concern.

Air conditioning and dehumidification in the summer are as important as adequate heating in the winter, especially with the decreased lung capacity and difficulty with handling extremes of temperature in the elderly.

To keep patients oriented, large "today is" calendars and large clocks should be displayed prominently on each wing of the unit, if not in each room. Paintings or lithographs in bright colors in the hallways and rooms help with orientation; bare walls do little to orient people (Whall & Conklin, 1985).

Staffing

It is proposed that a twelve bed unit be initiated as the base for this geropsychiatric program and such space is presently available at St.

Joseph Hospital West, due to the transfer of the Chemically Dependent Inpatient program to St. Joseph Health Center in St. Charles.

It is recommended that the following staff be assigned to this twelve bed geropsychiatric unit:

(Numbers represent Full Time Equivalency [FTE])

12.0		Nursing positions to include
	4	Registered Nurses,
	4-5	Licensed Practical Nurses and the remainder Certified Nurse Assistants
2.0		Social Workers
1.5		Recreational/Music therapists
.5		Occupational therapists
.5		Physical therapists
1.0		Geropsycologist
.5		Geropsychiatrist to serve as Medical Director
.3		Speech/Language Clinician
.1		Registered Dietician
.1		Registered Pharmacist
.1		Pastoral Care

The success of this unit will be determined by the ability of the staff to work effectively as an inter-disciplinary team to handle the many challenges and daily confusion of their patients. It is, therefore, recommended that all personnel have previous experience in programming for the elderly and have a genuine desire to serve this population (Liptzen, 1987).

Program Components

It is important to note that elderly patients benefit from the same psychotherapeutic techniques used with other (younger) inpatients. Gallagher and Thompson (1982) have done several studies that examine the effects of various psychotherapies on the elderly patient. Their reports have concluded that psychotherapy is as valuable for the older patient as it is for the younger patient (Tillman-Jones, 1990).

- **Group therapy**, offered three to five times each week, to explore and process such issues as discharge planning, current feelings, grief and loss, normal and abnormal changes associated with aging and life review.
- **Music therapy**, offered three times per week, to provide opportunities to reminisce upon past memories of special events/occasions in one's life, as well as to exert a physical effort into a pleasurable experience.
- **Self-Care Activities**, to assist with grooming activities, seven days per week at the beginning of each day; this is to enhance socialization and to restore personal care functioning; it will include selection and wearing of appropriate clothing.

- **Reality Orientation,** to emphasize the need for each patient to remain "current" with day, time, place and daily news, would be incorporated into most activities throughout each day.
- **Educational Groups,** to provide opportunities for learning about diet and nutrition, medication compliance, community resources, chemical dependency and discharge planning; this group will meet two to four times a week.
- **Socialization Groups,** to be held once a day to provide an opportunity for social interaction; these activities include special holiday celebrations, creative craft activities, current event topics, storytelling and a wide variety of games.
- **Physical Activity Groups,** to include such activities as stretching, walking, fresh air activity and PT/OT groups; these will be incorporated on a daily basis.
- **Pastoral Care Group,** to provide an opportunity to meet the spiritual needs of the patients, will be held once a week.
- **Relaxation Exercises,** to be provided as needed.
- **Family Education**, programs are to be held once a week and shall include such topics as Alzheimers' disease, nursing home placement, medication concerns, financial and community resources, etc.

- **Family Support**, programs are to be held once a week for families of the patient.
- **Caregivers Support Group**, offered to the community once-per-month for anyone who is a caregiver for the elderly.
- **Individual Therapy Sessions,** offered as needed, will be focused to assist each patient (as prescribed) to handle their various problems and to help each patient adapt to change.

  Alcoholics Anonymous (AA) attendance as prescribed by the patient's physician.
- **Brief Rest Periods** and light snacks will be provided on a 7-day per week basis, once in the morning and in the afternoon.

<u>Program Administration</u>

Primary supervision of this unit would be provided by the Medical Director and the Director of Nursing.

It is further recommended:

- that volunteers be encouraged and utilized on a daily basis, both for special assistance in one-on-one activities (like grooming, walking, etc.) and for additional support in group activities;

- that this program would fall under the auspices of the Mental Health Advisory Board and be included in topics of the St. Charles County Alliance for the Mentally Ill;
- that resource material be developed and aggressively distributed to the entire medical community in St. Charles, Warren, Lincoln and Pike counties;
- that resource materials would next be distributed to Nursing Home Administrators and Senior Citizen Community Centers throughout St. Charles, Warren, Lincoln and Pike Counties;
- that a goal of expanding this unit to fifteen beds within six to nine months of operation, shall become a primary focus of administrative attention.

Target Market

Marketing efforts will focus upon family physicians, psychologists, psychiatrists, neurologists, nursing home administrators and county mental health treatment centers. By targeting these individuals or contacts it will be quite possible to spread the word quickly about the new geropsychiatric program at St. Joseph Health Center and immediately answer the many questions of these referral

sources. It is most likely that these contacts will already know of individuals on their respective case loads who would instantly qualify for these services.

In summary, the development of a geropsychiatric treatment program at the St. Joseph Hospital West location would be an ideal solution to filling the visible gap in services that currently exists for the elderly in St. Charles, Warren, Lincoln and Pike Counties. Such a unit would be a compliment to the existing services offered by St. Joseph Health Center - St. Joseph Hospital West, especially in this highly competitive health care industry. It would, also, fit easily into the existing in-house referral system, whereby other treatment services (such as Physical Therapy, Occupational Therapy, Surgery, Dietary Assistance, etc.) could be instantly made available as each might need them. Supportive services for the St. Joseph Health Center - St. Joseph Hospital West system would find this new treatment program to be a simple, non-interruptive addition and instantly absorb its needs into their respective duties. A geropsychiatric unit is a very logical addition for St. Joseph Health Center and ensures the efforts of this health care vendor to maintain its status as the "leading" provider of health care services in St. Charles, Warren, Lincoln, and Pike Counties.

APPENDIX A

QUESTIONNAIRE FOR INTERVIEWEE OF GEROPSYCHIATRIC UNITS

I. History of the Unit.

A. What initiated the development of this unit?

B. How long has it been in existence?

C. How many beds do you presently have?

D. Other: Why did you decide to separate your geriatric patients from the acute patients; TX, money, etc.?

II. Admissions Criteria.

A. Age of the patient? (Average)

B. Diagnosis?

C. Other

III. Referrals.

A. From whom do you receive your admissions?

Physician? _____ What type of physician?_____

Family _____

Nursing Home _____

Community Mental Health _____

Department of Aging _____

Self _____

IV. Length of Stay.

A. What is the average length of stay?

B. What is your average daily census?

V. Reimbursement.

A. From whom do you receive reimbursement? (Percentage)

Medicare? _____

Medicaid? _____

Private Pay? _____

Other_____

VI. Assessments.

A. Who is responsible for assessing the patients?

B. Is there a particular assessment tool that you have found to be most useful in assessing the geropsyc patient? (name if possible)

VII. Discharge Planning.

A. Is there an aftercare program for these patients?

If so, how often do they meet?

B. Other

VIII. Staffing.

A. Do you have a Medical Director?

B. What staff work with geropsyc patients?

C. Do they have backgrounds in geriatric work?

D. I have read that there is a high rate of burn-out with geropsyc staff, is this true? How do you deal with this, as a manager?

E. Do you use a multidisciplinary approach to treatment?

If so, who makes up this team?

How often does this team meet?

F. Other

IX. Program.

A. What kinds of programs do the patients participate in?

B. Does nursing provide any programming?

C. What does activity therapy provide?

X. Are you DRG exempt?

XI. Staff Education.

REFERENCES

AGS Public Policy Committee. (1988). American geriatrics society position statement: Mental Health and the Elderly, Clinical Report on Aging, 2 (4), 9-10.

Applegate, W.B., Akins, D., Vander Zwagg, R., Thoni, K., Baker, M. (1983), A geriatric rehabilitation and assessment unit in a community hospital. Journal of America Geriatric Society, 31, 206-210.

Athley, R.C. (1991). Social Forces and Aging. Belmont, CA: Wadsworth Publishing Co.

Billig, N. & Leibeuloft, E. (1987). Special considerations in integrating elderly patients into a general hospital psychiatric unit, Hospital Community Psychiatry. 38 (3), 277-281.

Blazer, D., Hughes, D.C. & George, L.K. (1987). The epidemiology of depression in an elderly community population. Gerontologist. 27, 281-87.

Butler, R.N., Lewis, M. & Sunderland, T. (1991). Aging and Mental Health. New York: Macmillan Publishing.

Calkins, Margaret (1987). Designing special care units: A systematic approach. The American Journal of Alzheimer's Care and Research.

Diagnostic and Statistical Manual of Mental Disorders (1987) 3rd edition, revised, Washington D.C.: American Psychiatric Association.

Folstein, M.F., Folstein, S.E., McHugh, P.R. (1975). Mini-mental state: A practical method for grading the cognitive state of patients for the clinician. Journal Psychiatric Res, 12, 189-198.

Ford, C.V., & Sbordone, R.J. (1980). Attitudes of psychiatrists toward elderly patients. American Journal of Psychiatry, 137, 571-575.

Gaitz, C., & Varner, R. (1982), Principles of mental health care of elderly patients, Hospital and Community Psychiatry, 33, 127-133.

Gallagher, D. & Thompson, L.W. (1982). Differential effectiveness of psychotherapies for the treatment of major depressive disorder in older adult patients. Psychotherapy: Theory, Research, and Practice; 19, 482-490.

Glynn, N.J., (1993). Special care units for dementia, Journal of Gerontological Nursing.

Guidelines for Psychiatric Hospital Programs, (1989). The National Association of Private Psychiatric Hospitals.

Gurland, B.J., Dean, L., Cross, P., & Golden, R. (1980). The epidemiology of depression and dementia in the elderly: The use of multiple indicators of these conditions. In Cole, J.O., & Barrett, J.E., eds, Psychopathology of the Aged.

Heacock, P., Walton, C., Beck, C. & Mercer, S. (1991). Caring for the cognitively impaired, Journal of Gerontological Nursing.

Hogstel, M.O. (1990). Geropsychiatric Nursing. St. Louis: C.V. Mosby.

Holmes, D., Teresi, J., & Monaco, C. (1992), Special care units in nursing homes prevalence in five states, The Gerontologist, 32 (2).

Kane, R.A. & Kane, R.L. (1981). Assessing the elderly. Lexington, Mass: Lexington Books.

Kiernan, K., & Stoudemire, A., (1989). General Hospital Psychiatry. 11, 109-118.

Klerman, G.L., Lareori, P.W., Rice, J., Reich, T., Endicott, J., Andreasen, N.C., Keller, M.B., & Herschfield, R.M.A. (1985). Birth cohort trends in rates of major depressive disorder among relatives of patients with affective disorder. Archives of General Psychiatry, 42, 689-93.

Kujaivinski, J., Bigilow, P., Diedrich, D., Kikkebusch, P., Korpan, P., Walczak, J., Maxson, E., Ropski, S., & Farran, C.J. (1993). Research considerations geropsychiatry unit evaluation, Journal of Gerontological Nursing.

Pies, R. (1987). Psychiatric presentation of medical illness in the elderly. Geriatric Medicine Today, 6 (8), 39-53.

Rick, C.L., Young, D., & Fowler, R.C. (1986). San Diego suicide study. Archives of General Psychiatry, 43, 577-82.

Silverstein, S., (1981). A light in the attic. Minneapolis: Wesley Press.

Sunderland, T., Lawlor, B.A., Molchan, S.E., & Martinez, R.A. (1988). Depressive syndromes in the elderly: Special concerns. Psychopharmacology Bulletin, 24, 567.

Tillman-Jones, T.K. (1990). How to work with elderly patients on a general psychiatric unit. Journal of Psychosocial Nursing, 28 (5).

U.S. Bureau of the Census (1984). Projections of the population of the United States, by age, sex, and race: 1983 to 2030. Current Population Reports, P-25 (952).

VonBrook, P., Siegel, M.A., & Jacobs, N.R. (1990). Information plus, growing old in america.

Whall, A.L. & Conklin, C. (1985). Why a psychogeriatric unit? Journal of Psychosocial Nursing.

Welden, B.M. & Frose, K. (1991). Admission criteria for a special care unit for residents with dementia. Canadian Journal of Nursing Administrations, 17-21.