Availability of mental health services for older adults: A cross-cultural comparison of the United States and Turkey

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Abstract
Researchers conducted a cross-cultural study using qualitative methods (based on a phenomenological approach) to explore the availability of mental health services (MHS) for older adults in the United States and Turkey. Using purposive sampling, semi-structured in-depth interviews were conducted with administrators (n = 24) from a wide-range of sites (nursing homes, hospice, senior centers) in a rural area of North Central Florida, United States and Ankara, Turkey. Interview questions focused on types of staff employed; integration of MHS with other services provided; community promotion of services; coordination, cooperation and communication with other service providers; and administrators’ perceptions of barriers in the provision of MHS for older adults. Interestingly, employing on-site mental health staff was a much more popular practice in Turkey compared to the United States with three times as many Turkish sites having on-site mental health professionals. As anticipated, administrators in both countries cited inadequate funding as the most common barrier to MHS provision. Potential solutions to MHS barriers in both countries are discussed.

Introduction
One of the most striking characteristics of the world population in the new millennium is the considerable increase in the number of older adults worldwide. Currently, 606 million of the world’s total population of six billion is older than 60 years of age, and this figure is expected to rise considerably over the next 25–30 years (United Nations Department of Economic and Social Affairs, 2001). In the United States, approximately 13% of the population is aged 65 or older. As the baby-boomer cohort (people born during the post war period 1946–1964) ages, this number is expected to almost double by 2030 (Kinsella & Velkoff, 2001). In comparison, Turkey is relatively younger with people 65 and over constituting only 5.8% of the population. However, similar to the United States, this proportion is expected to increase almost to 12.9% over the next 25 years.

The connection between longevity and industrialization is well established, as developed countries in North America and Northern Europe are comparably older than less developed countries. Despite this, approximately 60% of the world’s elderly population lives in developing countries, and 77% of the increase in the world’s elderly population between 1999 and 2000 occurred in developing countries. The rapid rate of increase is expected to continue, and this proportion is projected to hit 71% by 2030 (Kinsella & Velkoff, 2001).

The significant increase in the ‘quantity’ of older adults in developed and developing nations worldwide raises important questions regarding whether their ‘quality’ of life will experience a corresponding increase. As people add years to their lives, ‘adding life to their years’ remains an important goal. Research examining the connection between well-being in later life and mental health has found that most older adults describe well-being as a combination of both physical and mental health (Jamjan, Miliwan, Pasunant, Sirapo-Ngam & Porthiban, 2002; Singh & Fiatarone-Singh, 2000; Von Faber et al., 2001). Such research highlights the importance of mental health for successful aging and life quality in later life.

Older adults have unique mental health needs, because they face a variety of age-related challenges (Weiss, 1995). The physical challenges of aging often receive the most attention (e.g., declines in mobility and physical health; medical conditions, such as Alzheimer’s disease and dementia; sleep disturbances [Boey, 1997; McCrae et al., 2003; Vitiello & Borson, 2001]). However, the biopsychosocial
model of aging recognizes that biological challenges are not the only ones that older adults face. Psychological (e.g., emotional isolation [Grady, 1990], depression [Ergene, 1989; Hegel, Stanley & Arean, 2002], death anxiety [Senol, 1989; Wu, Tang & Kwok, 2002]) and social (e.g., retirement [Jaman & Jerayingmongkol, 2002]; loss of independence, loss of spouse and/or friends [Golsworthy & Coyle, 1999]) factors can also be problematic. Frequently, multiple biopsychosocial challenges interact. To help older adults cope with these challenges, various mental health interventions have been developed, including retirement and pre-retirement counseling; assertiveness training; bereavement and grief counseling; individual, couple and family therapies (Kennedy & Tanenbaum, 2000; Qualls, 1993); and peer counseling (Bratter & Freeman, 1990; LaFollette & Rowe, 1994; Santa Monica Medical Center, 1994). Unfortunately, older individuals who might benefit from such interventions frequently do not have adequate access to mental health services (MHS). In the present research, we were specifically interested in whether older individuals in a developed nation such as the USA would have greater availability of MHS than older individuals in a developing nation, such as Turkey.

There is reason to believe American older adults may have greater access to MHS than Turkish older adults as the growing needs of the older adult population were recognized early in American history. In 1965, two healthcare programs that benefit senior citizens were established: Medicare, a federally funded program for citizens 65 and older (Hendricks, Hatch & Cutler, 1999), and Medicaid, a federally/state-funded supplemental program for the poor and needy, including older adults without private healthcare insurance and for whom Medicare alone was not sufficient. In addition, the United States has a rather large ‘aging network’ consisting of various organizations that plan and deliver services to older adults (Mid Florida Area Agency on Aging, 2003). This network includes federal and state organizations as well as public and private service providers at the local level. The common goal of these organizations is to promote life quality for older adults by working together to translate state and federal monies into community-based services for older adults.

By comparison, the delivery of elder services in Turkey is rather fragmented and not as well organized as in the USA. Elder services are mostly confined to institutional care settings (i.e., nursing homes), which are limited in number and individual capacity (Kilic, 1995), and only a few senior centers are available in the capital city. The Institution of Social Services and Child Protection (SHCEK) Act was passed in 1982, authorizing SHCEK to organize, deliver and inspect the provision of services for various disadvantaged populations in Turkey, including people with disabilities, the homeless, orphaned children, and the elderly. One of the goals of SHCEK and its corresponding institutions is the provision of services that address the social, physical and psychological needs of older adults (Institution of Social Services and Child Protection, 2004). However, not all sites, organizations or institutions providing services for older adults fall under this umbrella. In Turkey, there is no solid aging network as there is in the USA.

Although interventions that specifically target issues relevant to older adults have been developed as previously mentioned, the bulk of research in the field of mental health has focused primarily on younger client populations. Recently, in the USA, the mental health needs of older individuals have begun to receive greater attention. In contrast, Turkey is still lacking important research regarding mental health and older adults.

Sites ranging from day-care settings, hospices and assisted-living facilities to senior centers are established in the USA with a desire to extend the quality, as well as the quantity of older individuals’ lives. On the other hand, sites available to older adults in Turkey are mostly nursing homes, and there is a lack of variety in the settings providing service. By exploring the availability of MHS for older adults at various settings both in the USA and in Turkey (a developed and a developing country), this study is expected to fill a gap in the scientific literature focusing on aging research. To date, there has never been a cross-cultural research study investigating the availability of MHS in the USA and Turkey.

The purpose of the present paper is to report the results from a cross-cultural research study that explored the availability of MHS for older adults and barriers to service provision in the two countries. Data from semi-structured in-depth interviews with different site administrators are presented, and potential solutions to address each country’s unique barriers to service provision will be discussed.

Methods

Sampling

Qualitative sampling methods based on a phenomenological approach were used in data collection. The phenomenological approach involves identification of phenomena through the perceptions of the actors in a situation (Bogdan & Taylor, 1975). Purposive sampling (Lincoln & Guba, 1985; Shaughnessy & Zechmeister, 1997), a non-random sampling method in which the individuals are selected because they have expertise or experience related to the purpose of the study, was used. We recruited administrators from a variety of sites providing service to older adults as part of the aging network in the research locations. In order to qualify for the study, site administrators in both samples...
were required to have at least 1 year of administrative experience.

Semi-structured in-depth interviews were conducted with administrators from a wide range of sites providing services to older adults. In the United States, we interviewed administrators from 12 sites (1 hospice; 1 community mental health center; 3 nursing home facilities; 1 geriatric psychiatry unit at a hospital, 2 senior centers; 2 assisted living facilities [ALF]; 1 elder services agency that provides a variety of services such as congregate meals, homemaking, transportation and day-care; 1 senior health care center) in a rural area of North Central Florida. Likewise, we interviewed, administrators from 12 sites (n = 12, 2 senior centers, 1 geriatric unit at a hospital, 9 nursing home facilities) in Ankara, the capital of Turkey. The samples from the two countries were assumed to be equivalent, because the variety of sites available in Florida (the state with the highest percentage of elderly residents in the USA; US Census Bureau, 2003) was comparable to that found in Ankara (See Appendix A for a more detailed description of the sites).

Instruments

English and Turkish versions of a researcher-designed, semi-structured interview were used (See Appendix B for the interview guide) in data collection. The interview guide was prepared in English by the Turkish and American researchers. In the USA, three expert judges reviewed the primary interview guide (S. Bluck, M. Diehl, C. McCrae, personal communication, September 16, 2002). All three judges have experience conducting aging-related research, and one is also a licensed clinical psychologist with experience in the provision of MHS to older adults. Based on the comments of these experts, minor revisions were made to refine the instrument. The refined interview guide was then pilot-tested on three administrators in the USA to ensure questions were understood. In Turkey, the interview guide was translated into Turkish by the Turkish researchers. Three judges with a good command of English reviewed the Turkish interview guide and checked interview questions for language accuracy and cultural-relevance (G. Cakir, O. Karaimak, N. Duran, personal communication, June 23, 2003). After minor revisions, the Turkish interview guide was pilot-tested on three administrators to ensure interview questions were well understood.

Open-ended questions in both the English and Turkish versions of the interview guide focused on: (1) the types of staff employed on-site; (2) types of services provided and integration of MHS with other types of services provided on-site; (3) community promotion of services; (4) sites’ coordination, cooperation and communication with other service providers within the aging network; and (5) administrators’ perceptions of barriers in the provision of MHS for older adults.

Extensive quotations from the interviews are cited in the results section in order to help establish the internal validity of the instrument. These quotations help to illustrate how the results presented are consistent with the data collected. To establish the reliability of coder agreement, each interview transcript was reviewed three times, and the results of these multiple reviews were highly consistent (κ = 0.87 for the level of agreement in the American data, and κ = 0.85 for the level of agreement in the Turkish data).

Procedures

Site administrators were contacted to schedule an appointment for the interview and to provide a tour of the facility. One of the researchers interviewed each site administrator and toured the sites’ facilities both in Turkey and the USA. The interviews were tape-recorded and took approximately 20–45 minutes each.

Data analysis

Recorded interview sessions were transcribed and content analyses were performed in order to identify recurrent themes. Each interview session was analyzed sentence-by-sentence and a coding scheme based on recurrent themes was created. Each session was reviewed three times in order to establish the reliability of the data. Excerpts from the interviews highlighting the recurrent themes are provided in the results section.

Results

Types of staff employed on-site (number of sites out of 12)

Nursing staff were the most common in the American sample, employed by eight sites; followed by social workers, employed at six sites. Mental health professionals were relatively rare (e.g., an on-site psychiatrist was available at only one site). Likewise, a counselor/family therapist was available at only one site. Consulting outside mental health professionals on an ‘as needed’ basis was a popular practice, occurring at six of the 12 sites. Three sites provided no access to mental health professionals.

In the Turkish sample, social workers were the most common on-site staff, employed at 11 sites, followed by nursing staff, employed at 10 sites. In contrast to the American sample, employing on-site mental health staff was a popular practice in Turkey, with psychologists employed at six sites. See Table I for a summary of mental health professionals by type of site for the American sample, and Table II for the Turkish sample.
Table I. Types of on-site mental health professionals (United States).

<table>
<thead>
<tr>
<th>Type of site</th>
<th>Nursing home (n = 3)</th>
<th>Hospice</th>
<th>Geriatric psychiatry unit at hospital</th>
<th>ALF (n = 2)</th>
<th>Elder services agency</th>
<th>Senior center (n = 2)</th>
<th>Senior health care center</th>
<th>Community mental health center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of mental health staff</td>
<td>No on-site mental health staff</td>
<td>Masters in Counseling, Masters in Family Therapy</td>
<td>No on-site mental health staff</td>
<td>No on-site mental health staff</td>
<td>No on-site mental health staff</td>
<td>No on-site mental health staff</td>
<td>No on-site mental health staff</td>
<td>No on-site mental health staff with gerontological training</td>
</tr>
</tbody>
</table>

Table II. Types of on-site mental health professionals (Turkey).

<table>
<thead>
<tr>
<th>Type of site</th>
<th>Nursing home (n = 9)</th>
<th>Senior center (n = 2)</th>
<th>Geriatric unit at hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of mental health staff</td>
<td>Psychologist (n = 6), no on-site mental health staff</td>
<td>No on-site mental health staff</td>
<td>No on-site mental health staff</td>
</tr>
<tr>
<td></td>
<td>(n = 5)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Nursing staff included RNs (Registered Nurse) and those described as nursing staff; social workers included Social Workers and Licensed Clinical Social Workers; whereas the mental health professionals category included full-time psychiatrists, counseling professionals, psychologists and other therapists. The excerpts below illustrate the limited employment of on-site mental health professionals for the American sample:

'We are not a mental health facility; therefore, there are no full-time mental health professionals on our site. We are licensed as a skilled nursing facility, so that’s the service we really provide... As for mental health services, it would be all the outside services, if the attending physician orders psychiatric consult... we are like the middle man, we only follow the doctor’s orders’.

[Nursing home administrator, #1]

'We consult outside resources, we do not employ them on-site’.

[ALF administrator, #1]

'No... we never had any one (mental health professional)... we never had the opportunity to tap through, to even look in that direction’.

[Senior Center Administrator, #1]

Types of services provided and integration of MHS with other services provided on-site

In the American sample, medical/physical care services (supervision of medication, physical therapy, occupational therapy) were the most commonly provided services (8 sites), followed by nursing care (assistance with personal care and ADLs) (7 sites), and social activities (5 sites). Mental health services were provided by less than half the sites (5 sites) and included out-patient grief and bereavement counseling (1 site), support groups (2 sites, led by a nurse at 1 site), a behavior management group (1 site), and an older adult coping group led by outside mental health professional (1 site). Only two sites provided Mental Health Status Examinations and Cognitive Screening, and only one site provided Emotional Status Evaluations.

In the Turkish sample, social activities were the most common (9 sites), followed by nursing care (8 sites) and medical/physical care (7 sites). Mental health services were provided by half of the sample (6 sites). Specifically, services provided included guidance and support (1 site), assessment (2 sites), individual (4 sites) and group (2 sites) interventions, and regular reports regarding elders’ psychological well-being (3 sites).

Community promotion of services

In the American sample, most sites relied on ‘word of mouth’ (e.g., church talks, community education programs, presentations, etc; 9 sites). Local media (e.g., radio, television, newspapers) was utilized by eight sites, and printed advertisements (e.g., fliers, brochures) were the third most commonly mentioned form of promotion (7 sites). Professional liaisons (i.e., cooperation among physicians, hospitals, discharge planners, and other referral resources) were equally frequent (7 sites). Yellow pages were used as another way of promoting services to the community (4 sites). Other methods (each reported by 3 sites) included relying on site’s reputation, the Internet, attending senior health fairs, and participation in other community organizations, such as the Chamber of Commerce and United Way.

In the Turkish sample, relying on site’s reputation was the most common community promotion (6 sites), with yellow pages and printed advertisements second most common (4 sites each). Using the Internet (3 sites) was followed by other methods, such as television, radio, and word of mouth (giving talks to visitors, volunteers, charities; 2 sites each). Table III provides a summary of the methods of community promotion of services utilized by type of site for the American sample, and Table IV for the Turkish sample.
Coordination, cooperation and communication with other service providers

Interviews from the American sample revealed that the majority of sites communicate and coordinate well, referring back and forth, and in some cases, cooperating in order to provide effective services (9 sites). However, three sites reported low levels of coordination, cooperation and communication with other service providers within the aging network. The excerpts below help to illustrate this contrast. The first two examples are from administrators reporting high levels of coordination, cooperation and communication, and the last two are from administrators reporting low levels of coordination, cooperation and communication:

'We work pretty well with other service providers... easily access the aging network for coordinating... but haven’t taken steps for cooperation’.
[Administrator of a Geriatric Psychiatry Unit at a hospital]

'We work with other sites and organizations on a continual basis... We do need to coordinate and communicate with other service providers a lot... Cooperation is really very good. We are making sure that we are delivering a quality service together. We communicate back and forth, and I think the communication flows very well from this facility, too’.
[ALF administrator, #2]

The last two examples are from administrators reporting low levels of coordination with other service providers.

‘I don’t have anyone I can contact. I don’t have any networking channels to go through or work through... for the most part I do it all. I don’t even know any nursing homes. As for communication, on my part, it’d be really appreciated but now I think it’s very low...’.
[Senior Center Administrator, #1]

‘We do have access to information that we do give them. For cooperation and communication (within the department they are connected to) some people are ready to cooperate, some are not; they do their own thing, not like networking to benefit the seniors’.
[Senior Center Administrator, #2]

Interviews from the Turkish sample revealed similar results as in the American sample. The majority of sites reported good levels of coordination and communication (9 sites), and some level of cooperation on special occasions (7 sites). Three sites, however, reported low levels of coordination, cooperation and communication with other service providers within the aging network. Excerpts below illustrate this contrast. The first two examples are from administrators reporting high levels of coordination, cooperation and communication, and the last two are from administrators reporting low levels of coordination, cooperation and communication:

'We have very well connections with other nursing homes, Mayor’s Office of Elder Services, banks, universities, local theatres... we also cooperate on a good level... there’s a good flow of communication, too; together, we are able to locate essential resources whenever needed’.
[Administrator of Senior Center, #1]

'We have continuous liaisons with other organizations, NGOs, local merchants, banks, ministries, donor associations... we cooperate with other sites and organizations on special occasions, arrange reciprocal visits with other nursing homes... picnic together. There’s a good level of communication with...'
[ALF administrator, #2]
other organizations in the area, which works well to locate the essential resources for our elders'.

[Administrator of Nursing Home, #2]

‘There isn’t much coordination other than referrals, hospital transfers and get-togethers on special days… no cooperation, either… We are open to cooperation, but there isn’t much interest from other sites’.

[Administrator of Nursing Home, #5]

‘No coordination except the institutions that fall under the same umbrella with us… others are closed to cooperation and communication, too’.

[Administrator of Senior Center, #2]

Perceptions of barriers in the provision of MHS for older adults

Eight administrators from the American sample reported that limited financial resources constituted the biggest barrier to providing MHS to older adults. Specific financial barriers included limited funding and cutbacks from federal and state governments (7 sites) and limited MHS coverage through Medicare and poor reimbursement of mental health (as well as medical) services in Medicaid because both programs lack parity between medical and MHS (4 sites). Most administrators described having to advocate for their older clients in order for them to receive needed MHS (5 sites). The excerpts below illustrate the impact that governmental budget cuts have had on the provision of MHS for older adults.

‘…budget cuts are tough for community agencies serving older adults. We advocate for getting resources for clients’ needs, care and comfort…’.

[Hospice administrator]

‘Having indigent population at site, you have to rely on Medicaid… Once you identify a need that resident has for services, to get them paid for we wind up having to pay some of that, and it really pulls down the payment issues… Sometimes we can’t get providers in the building, or get access to them outside of the building for the resident, because they don’t accept Medicaid, sometimes that creates barriers. If we have more money, we can do more. There’s only limited amount of money and we have to do with what we’ve got’.

[Nursing home administrator, #1]

‘It’s more of the financial barriers that we have. Medicare/Medicaid will only cover certain aspects… they provide partial coverage for mental health services and that becomes the financial part of it’.

[Nursing home administrator, #2]

‘Budget problems… Federal government is cutting back Medicare funds, in the 70s it was more of a growth-oriented kind of thing, we were starting new programs, but now we are cutting out programs, limited financial resources is the major barrier’.

[Nursing home administrator, #3]

‘…right now the funding is not very good. We can’t apply for the grants, because we don’t fall under the umbrella [of elder services]. If we want to better serve [elders], we have to get some funding from some place else, because right now the city just does not have the funding to adequately support. Funding is the biggest problem that we have’.

[Senior center administrator, #2]

‘Money. I mean, honest, because being grant and donation funded, it’s kind of the legislator gives it and legislator takes it away… some of them can see the big picture, some of them can’t… Last time they were talking about cutting the funding for the Alzheimer’s programs…’

[Elder services agency administrator]

Two administrators reported problems integrating with the aging network, and limited coordination, communication and cooperation with other service providers. The stigma of mental health issues for older adults, limited availability of qualified human resources, and barriers related to regulations (e.g., limited chances to employ on-site mental health professionals at skilled nursing facilities and ALFs) were also described as barriers (1 site each).

Similar to the American sample, eight administrators from the Turkish sample reported that limited budget and funding from the government was the biggest barrier to the provision of MHS to older adults. The excerpts below illustrate how limited funding effects the provision of MHS for older adults:

‘We have budget problems… here, we do need better building conditions, more space and more private, isolated rooms for one-on-one interviews… sometimes we need transportation for our elders… we need to hire an on-site psychologist or a counselor here to help our community-living, well-elderly members’.

[Administrator of Senior Center, #1]

‘The barriers to service provision are mainly financial. The building we use is not in a good physical condition… We have problems paying the bills and locating transportation for our elders… we need to hire a mental health staff for at least making referrals or consultations, such as a counselor or a psychologist to help provide a complete service to our seniors…’

[Administrator of Senior Center, #2]

‘Budgets are tight and administrators need to be very creative, we need to show extra fund-raising efforts’.

[Administrator of Nursing Home, #1]
We need a more home-like environment for our residents. Under these conditions, it’s hard to create a healthy psychological atmosphere here.

[Administrator of Nursing Home, #2]

Our residents can’t afford higher rates, so we try to provide a certain level of service quality with low rates, and that’s a financial barrier for us.

[Administrator of Nursing Home, #3]

Administrators also reported older adults’ reluctance to use MHS and lack of family involvement in helping older adults as additional barriers (3 sites each). Finding qualified mental health staff was also a barrier due to the lack of formal gerontological training for mental health professionals in Turkey (2 sites). See Table V for a summary of administrators’ perceptions of barriers in the provision of MHS for older adults by site for the American sample, and Table VI for the Turkish sample.

Table V. Types of administrators’ perceptions of barriers in the provision of MHS for older adults (United States).

<table>
<thead>
<tr>
<th>Type of site</th>
<th>n</th>
<th>Type of barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing home</td>
<td>3</td>
<td>Limited budget and reductions in funds, lack of parity for MHS in Medicaid/Medicare</td>
</tr>
<tr>
<td>Hospice</td>
<td>1</td>
<td>Budget cuts</td>
</tr>
<tr>
<td>Geriatric psychiatry unit at hospital</td>
<td>1</td>
<td>Stigma of mental health diagnosis for older clients</td>
</tr>
<tr>
<td>ALF</td>
<td>2</td>
<td>Lack of qualified human resources, regulations</td>
</tr>
<tr>
<td>Elder services agency</td>
<td>1</td>
<td>Limited funding, budget cuts</td>
</tr>
<tr>
<td>Senior center</td>
<td>2</td>
<td>Limited funding, site’s lack of integration into the Aging Network and difficulty getting funding for elder programs</td>
</tr>
<tr>
<td>Senior health care center</td>
<td>1</td>
<td>Funding issues outside of the site</td>
</tr>
<tr>
<td>Community mental health center</td>
<td>1</td>
<td>Only targets children and families with abuse issues and substance abuse, no specific programs geared towards older adults</td>
</tr>
</tbody>
</table>

Table VI. Types of administrators’ perceptions of barriers in the provision of MHS for older adults (Turkey).

<table>
<thead>
<tr>
<th>Type of site</th>
<th>n</th>
<th>Type of barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing home</td>
<td>9</td>
<td>Limited budget and funding, reluctance of elders to utilize MHS, lack of family involvement, lack of qualified human resources</td>
</tr>
<tr>
<td>Senior center</td>
<td>2</td>
<td>Limited funding</td>
</tr>
<tr>
<td>Geriatric unit at hospital</td>
<td>1</td>
<td>Reluctance of elders to utilize MHS</td>
</tr>
</tbody>
</table>

‘We need a more home-like environment for our residents... under these conditions, it’s hard to create a healthy psychological atmosphere here’.

[Administrator of Nursing Home, #2]

‘Our residents can’t afford higher rates, so we try to provide a certain level of service quality with low rates, and that’s a financial barrier for us’.

[Administrator of Nursing Home, #3]

Discussion

As the proportion of older adults in the world population increases over the next 30–50 years, greater numbers of people will spend more time in their ‘twilight years’ than ever before. Although developed nations such as the USA and developing nations such as Turkey alike will experience increases in their elderly populations, the majority of older adults will reside in developing nations. Older individuals in both developed and developing nations face a variety of biopsychosocial challenges (chronic illness, bereavement, retirement) that can have a major impact not only on their emotional well-being and mental health, but also on their overall quality of life. Although the mental health needs of younger populations have received greater research and clinical attention, psychological interventions that specifically target the needs of older adults have been developed. Unfortunately, our findings are in line with previous literature illustrating that many older adults do not have adequate access to MHS (Chumbler, Cody & Beck, 2001; Maiden & Peterson, 2002; Shea, Russo & Smyer, 2000). Interestingly, although the USA has a more integrated ‘aging network’ than Turkey, the majority of administrators we interviewed in the American sample represented sites that did not employ on-site mental health professionals. In contrast, half the administrators interviewed in Turkey represented sites that employed at least one on-site psychologist. Despite recognition of the importance of MHS in both samples, our results indicate the mental health needs of the elderly remain underserved in both countries. Not surprisingly, administrators from both the USA and Turkey cited ‘financial issues’ as their main barrier to providing MHS for their elderly residents.

In the USA, the mental health needs of elders are often viewed as both secondary to and disconnected from their physical needs. Nursing homes are typically licensed as skilled nursing facilities and rehabilitation centers. In our sample, neither nursing homes nor their new alternative, Assisted Living Facilities (ALFs), routinely employed on-site mental health professionals such as a full-time counselor or a psychologist. This is extremely unfortunate, because nursing home and ALF residents often have significant emotional concerns (adjustment problems, fears of loss of control and independence, and high rates of depression; Cummins, 2002; Kampfe, 2002). Despite the availability of on-site psychologists at half the Turkish sites, tight budgets and limited funding impact the delivery of MHS by restricting the number, variety and individual
capacity of these sites (Kılıç, 1995). The need for more integrative services for older adults appeared to be well recognized in Turkey (Institution of Social Services & Child Protection, 2004) as employing full-time mental health professionals was a popular practice. Unfortunately, due to the lack of formal gerontological training for mental health professionals in Turkey, the quality of MHS offered at these sites remains uncertain.

As anticipated, the main focus of sites in both the USA and Turkey was the provision of physical/medical services. This is particularly unfortunate, because neglected mental health needs, such as depressed mood, may exacerbate physical health concerns, leading to more severe consequences like malnutrition, loss of medical health, or even suicidal ideation, and possibly resulting in premature hospitalization or institutionalization, which frequently ends up costing the government more money in the long-run (Binstock, 1997). Both preventive and remedial MHS can enhance well-being in older adults and help them to age in place, living independently for as long as possible.

Community mental health centers are in an ideal position to reach out to large numbers of older adults in order to provide them with affordable MHS developed for their specific needs (Mosher-Ashley & Witkowski, 1999; Tiamiyu & Bailey, 2001). Unfortunately, in the present study the regional community mental health facility in the USA sample was not well integrated with the aging network and, therefore, did not offer any specific programs geared towards the elderly. In Turkey, community mental health centers do not exist and alternative private practice settings (e.g., hospitals, counseling centers) that are available mostly target younger populations. In both countries, there is a need for better development of and access to community-based guidance and counseling programs to preventively address the changes, stresses and losses of later life. If community mental health centers had specific programs for seniors, they could play a significant role in facilitating adjustment to the biopsychosocial challenges of later life as well as providing for continuous development, life satisfaction and growth.

Results of this study revealed that sites in the Turkish sample did not employ active promotional strategies to reach out to older adults in the community, but instead, relied on the reputation and presence of their sites. As in the USA sample, continued efforts in Turkey are needed in order to promote preventive and remedial MHS directly to older adults and their families by utilizing a variety of promotional strategies. Such strategies can include printed adverts, television interviews, or more direct methods such as talks, public meetings and seminars, which can all help increase awareness among older adults in receiving these services and involving their families in the helping process.

Well-planned, direct promotional activities targeting senior citizens in the community can help break through the frequently cited reluctance and resistance of older adults to seeking help and receiving MHS, which was also reported by administrators in this study (American Psychiatric Association, 1998; Qualls, Segal, Norman, Niederehe & Gallagher-Thompson, 2002; Riker & Myers, 1995). Such resistance is often attributed to the fact that when today’s older adults were growing up half a century ago, the social climate was not as favorably inclined toward the use of mental health as it is today. Educating older adults about the benefits of utilizing MHS and breaking through misconceptions and negative beliefs related to mental health care may help to reduce their resistance to accessing these services. Considering the multi-dimensional, biopsychosocial risks facing the aging population, different types of elder service providers can also be trained in order to combat ageism among different professionals and help enhance a team-approach for more effective service provision.

Senior centers are important resources for community-living older adults to socialize and develop new skills. Senior centers, however, were under-represented and not well integrated into the aging network in our USA sample. Because they are established as either community centers or recreation centers and not as facilities providing services specifically to older adults, they do not fall under the umbrella of the Aging Network. Therefore, they frequently have only limited access to federal monies for their elderly services. Establishing senior centers specifically for the social and emotional needs of older adults and helping these sites integrate into the aging network will benefit community living, well elderly and their families. In Turkey, access to preventive MHS for community-dwelling older adults represents a particular need, because despite their larger social networks and more frequent social interactions, community living Turkish older adults were found to have negative attitudes towards aging and to feel lonely and dissatisfied with their lives (Inamaölu, 1993).

Despite the absence of an ‘aging network’ per se in the Turkish sample, the majority of sites reported high levels of coordination, cooperation and communication with other service providers. Similar to the USA, however, there were several sites (n = 3) that reported low levels of coordination, cooperation and communication. Perhaps the establishment of a system that includes a variety of service providers similar to that available in the USA may help to improve Turkish elders’ access to MHS. However, this alone may not be adequate as in the USA even with the presence of an established aging network, several sites were not well-integrated with this network. Thus, in the USA, there is still work to be done in terms of creating a fully integrated aging network.
'Limited financial resources' was the most frequently cited barrier to the provision of MHS for older adults in both the USA and Turkey. In the USA, mental health needs of older adults continue to be overlooked and are often considered secondary to their physical needs. Interestingly, in Turkey, there appears to be an effort for a more integrative approach to service provision for older adults; however, service providers available are still limited in number and variety.

In both the Turkish and American samples, limited budgets impacted the main conditions necessary for the proper delivery and continuation of MHS for older adults (e.g., sites’ physical conditions, community promotion of MHS, finding qualified human resources, etc.). For the Turkish sample, financial barriers had the greatest impact on the facilities available for the basic delivery of MHS (e.g., private room for individual interviews, space for group interventions, better building conditions). This is largely attributable to the fact that service providers in Turkey are either part of SHCEK, which must provide services not only to the elderly but to a wide variety of other needy populations (e.g., the disabled, homeless, orphaned children) or must rely on private funding from donors and charities, which is frequently difficult to obtain. As a result of the lack of funding specifically targeted for older adults, facilities that provide services for older adults are frequently under-funded.

Recognizing older adults as a growing population, understanding their unique needs and restructuring the system for service delivery accordingly is essential in Turkey. An essential first step is greater recognition of the need for increased funding to increase the number and variety of resources reserved for older adults. Increasing legislators’ awareness of the crucial role that MHS can play in increasing life quality and personal growth in late adulthood is particularly important. In addition, greater focus on preventative MHS may help to reduce the ‘long-term’ costs of poor mental health, including exacerbation of physical illness and premature institutionalization.

The number, variety and individual capacity of sites providing service to older adults also needs to be increased and made available to Turkish older adults and their families. Reluctance of older adults to use MHS and lack of family involvement in the service provision can be overcome through effective, active and direct promotional activities (e.g., giving talks, seminars, TV programs, advertising, etc.). This way, utilization of MHS by older adults can be facilitated and involvement of their families can be enhanced by restructuring possible misbelieves and misconceptions about MHS.

Finally, in Turkey, steps should be taken in order to establish formal gerontological training for mental health professionals. Without qualified human resources (i.e., psychologists, counselors and other mental health professionals with gerontological training), attempts to provide an integrative service to older adults will unfortunately be in vain. In-service training and continuous education is necessary to help current mental health professionals better serve the growing aging population and meet their mental health needs effectively.

Results from the American sample, on the other hand, are in line with Jane Myers’ earlier views (Myers & Schwiebert, 1996) that older adults’ physical needs are prioritized over their mental health needs in America as physical/medical needs are prioritized as evidenced by the types of staff employed and services provided (i.e., nursing homes, ALFs, senior healthcare centers). Despite growing awareness of the ‘mind-body’ connection and mounting evidence of the importance of mental health to elders’ physical health and overall well-being (Alpass & Neville, 2003; Gill & Kelley, 1994; Heidrich & D’Amico, 1993), recent policy changes in the USA have significantly reduced the amount of funding for MHS for older adults. These cut backs are discouraging for everyone involved—mental health professionals, providers of elder services, and older adults alike. If nothing is done to remedy this situation, it will likely worsen over the next 30–50 years.

Lack of parity between medical care and MHS in the governmental health insurance programs constitutes the major barriers for the provision of essential MHS for older adults. For example, Medicare reimburses 50% of outpatient MHS; whereas the reimbursement rate for medically necessary services is 80%. Prescription drugs are not covered unless the individual is hospitalized. There is no lifetime limit on the number of days for general hospital care, whereas the limit for inpatient MHS is 190 days (Medicare, 2004). In addition, coverage for MHS in both Medicare and Medicaid is often conditional (i.e., a medical doctor must provide supervision and must make a referral stipulating that the mental health issue represents a severe and disabling illness) and time-limited (there is often a ‘cap’ on the number of mental health visits covered; ACT Mental Health Services, 2003; Becker, Stiles & Schonfeld, 2002). Lack of parity in third party insurance reimbursements and higher co-payments for MHS can increase out-of-pocket expense for older adults to the point that they no longer even attempt to seek help for mental health related issues.

In the community, reimbursement for MHS is often well below the usual fees of private practitioners, and as a result, some practitioners turn away from older adults using these health insurance programs.

Conclusion
The USA, a developed country with substantial financial and human resources, can meet the multi-dimensional needs of its senior citizens by taking a more integrative approach and improving parity in
service provision. Turkey, a developing country, already has a more integrative approach to service provision, but has fewer financial and human resources. To improve Turkish elders’ access to MHS, the focus needs to be on increasing the number, variety and capacity of sites providing service to older adults. Establishing parity between older adults’ mental and physical needs with the two existing federal health insurance programs in the USA is crucial to the availability and accessibility of MHS for today’s and tomorrow’s senior citizens. The organized, collaborative effort of field professionals in both countries is necessary not only for helping to expand funds for community-based mental health programs, but also for increasing older adults’ access to these services.

All in all, the recognition of older adults’ mental health needs by authorities in the developed and developing world is an extremely important issue, as the increasing aging population becomes a new force worldwide. By the year 2030, when the baby boomer cohort—who are more open to seeking help compared to their parents—reaches age 65 (Koenig, George & Schneider, 1994), the field of mental health in the USA will be facing both the challenge and the opportunity of a much-increased demand for MHS. Developing countries like Turkey will also need to take notice of the rapidly growing aging population and establish a well-organized aging network for integrative service provision, and expend funds necessary to deal with elder affairs. Recognizing older adults as a population with unique, multidimensional needs, and adopting an integrative approach to address both their physical and mental health needs is essential for developed and developing nations around the world.

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**Appendix A**

**United States sample**

<table>
<thead>
<tr>
<th>Type of site</th>
<th>Number of residents/site’s capacity</th>
<th>Number and type of on-site specialized personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing home #1</td>
<td>197/222</td>
<td>Social worker (n = 1)</td>
</tr>
<tr>
<td>Nursing home #2</td>
<td>195/200</td>
<td>Social worker (n = 2)</td>
</tr>
<tr>
<td>Nursing home #3</td>
<td>28/34</td>
<td>Social worker (n = 1)</td>
</tr>
<tr>
<td>Hospice (In/outpatient, varies/16 county areas in North Central Florida)</td>
<td></td>
<td>Social worker, Masters of counseling, Masters in family therapy (n = 1 each)</td>
</tr>
<tr>
<td>ALF #1</td>
<td>31/34</td>
<td>No on-site mental health staff</td>
</tr>
<tr>
<td>ALF #2</td>
<td>103/110</td>
<td>No on-site mental health staff</td>
</tr>
<tr>
<td>Senior center #1</td>
<td>65 members</td>
<td>No on-site mental health staff</td>
</tr>
<tr>
<td>Senior center #2</td>
<td>74 members</td>
<td>No on-site mental health staff</td>
</tr>
<tr>
<td>Elder services agency</td>
<td>Approximately 1200 service users</td>
<td>No on-site mental health staff</td>
</tr>
<tr>
<td>Senior health care center</td>
<td>Outpatient, varies</td>
<td>Licensed clinical social worker (n = 1)</td>
</tr>
<tr>
<td>Regional community mental health center (Outpatient, varies/10 county areas in North Central Florida)</td>
<td></td>
<td>No on-site staff with gerontological training</td>
</tr>
<tr>
<td>Geriatric psychiatry unit at hospital</td>
<td>12/24</td>
<td>Psychiatrist (n = 2), social worker (n = 1)</td>
</tr>
</tbody>
</table>
Appendix B

Interview guide (site administrators)

Types of staff
- 'Please describe the size and background of your staff. For example, how many nurses do you employ?'
- 'How many mental health professionals do you have on staff?'
- 'What types of services do you generally provide?'
- 'What types of mental health services do you provide?'
- 'How do you promote your services to older adults in your community?'
- 'What are some of the methods you have used to reach older adults?'
- 'How do you interact with related agencies in terms of coordination of services for older adults?'
- 'How do you interact with related agencies in terms of cooperation in providing services for older adults?'
- 'How do you interact with related agencies in terms of communication related to the provision of services for older adults?'
- 'Please describe at least three problems/barriers that you/your site face in providing mental health services to older adults. Please rank these barriers in order from most important to least important.'

Types of services

Community promotion of services

Coordination, cooperation and communication

Problems/Barriers
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