AN INVESTIGATION OF THE OLDER ADULT'S PREFERRED SOURCES OF ASSISTANCE FOR MENTAL HEALTH SERVICES

By

BARBARA KAY SHELTON

Bachelor of Arts in Journalism
University of Oklahoma
Norman, Oklahoma
1966

Master of Education
University of Oklahoma
Norman, Oklahoma
1968

Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fullfillment of
the requirements for
the Degree of
DOCTOR OF EDUCATION
December, 1982

AN INVESTIGATION OF THE OLDER ADULT'S PREFERRED SOURCES OF ASSISTANCE FOR MENTAL HEALTH SERVICES

Thesis Approved:

Thesis Adviser

Judith E. Dobson

Joseph Pearl

Nona Jo Campbell

Gene Auff

Norman N. Durham

Dean of Graduate College

PREFACE

This study is concerned with the factors influencing utilization of mental health services by the older adult. The primary purpose of the study was the identification of characteristics of the service delivery method which effect the older adult's perception of the acceptability of these mental health services. Using a service utilization model, various service delivery methods characterized as having high acceptability, moderate acceptability, or low acceptability were rated by older adult participants.

The author wishes to express appreciation to members of the advisory committee: Dr. James Seals, Chairman; Dr. Jo Campbell; Dr. Judith Dobson; Dr. Joe Pearls, and Dr. Gene Acuff. Appreciation is also extended to the directors, staff, and participants of the senior citizens programs in Pontotoc County without whose assistance this project would not have been possible.

A debt of gratitude is also expressed to the faculty and staff at East Central University for the support and assistance provided during the course of this investigation. Particular thanks to the members of the reference section of the East Central University library. Thanks to Ms. Carrol Maxwell for her assistance and valuable comments regarding the preparation of the manuscript.

Finally, I would like to acknowledge the continuing support and encouragement I have received from friends and family. The understanding and patience of loved ones lightened the load and will always be remembered.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

GENERAL INTRODUCTION TO THE AREA OF STUDY

Introduction

In the United States the proportion of the over 65 age group is the most rapidly growing segment of our population. Currently, the elderly comprise approximately 11% of our population (Fowles, 1978). By the year 2030 it is estimated that this age group will represent 18% of our total population (Subcommittee on Human Services, 1980). This shift in our population, coupled with the fact that society has never had so many older citizens living so long, has focused much attention on the needs and desires of the older adult.

As we have more people over the age 65 and as these individuals live longer, new problems are created for the delivery of social services (Subcommittee on Human Services, 1980). Informal services which met the needs of relatively few individuals in the past are no longer adequate to meet the needs of today's large number of older adults (Gold, 1974). Initial efforts in the field of gerontology have focused on the basic needs of this target group such as the need for adequate income, food, and shelter. Attention is now shifting to those needs which influence the quality of life. Vontress (1968) and Porter (1970) identified the

educational counseling needs of older adults. Buckley (1972), Blake (1975), and Salisbury (1975) criticized the counseling profession for its lack of involvement in preparing professionals to meet the needs of the older adult. By 1980 Barry noted a growing interest in the "aging and their needs" (p. 122). In a study conducted by Wantz, Scherman and Hollis (1982), counselor education programs reported adding 80 new courses in gerontological counseling making this the third most frequently added area of study. This is in sharp contrast to the previous findings of Salisbury in 1975 where there were no required courses and only 18 elective courses in gerontological counseling.

Other evidence of this trend is seen in the increased importance placed on programs to meet the mental health needs of the older person and the increase in real numbers of such programs (Larsen, 1977; Norris & Larsen, 1976). Also, projects such as the American Personnel and Guidance Association's Counseling the Aged (Ganikos, 1979) have been funded to increase the knowledge of counselors regarding this target group. However, there is a lag between the development of this knowledge and the delivery of mental health services (Butler & Lewis, 1982).

The need of the older adult for mental health services is indicated by a variety of data such as the high suicide rate for older, white males (Miller, 1978); the number of older individuals institutionalized needlessly as reported by Butler (Select Committee on Aging, 1979); and the

expressed needs of older adults themselves (Myers, 1978). However, the older adult does not use mental health services in proportion to the general population (Federal Council on the Aging, hereafter referred to as FCOA, 1981). The popularity and rapid expansion of nontraditional forms of mental health assistance (Fields, 1980; Salmon, 1981; Larsen 1977; Waters, Fink & White, 1976) suggest that it is the method of service delivery which is acceptable or not acceptable to the older adult rather than a reluctance to deal with mental health issues.

Statement of the Problem

The focus of this study was the problem of identifying characteristics of acceptable resources for meeting the mental health needs of older adult.

Purpose of Study

The purpose of this study was to (1) identify factors which seemed to influence utilization of mental health services by older adults, (2) outline a comprehensive model of these factors, (3) isolate those factors which were under the control of the service delivery agency and (4) test the influence of these factors by means of a descriptive study employing a survey of older adults' preferences for sources of assistance.

Research Questions

The following research questions guided the course of this investigation:

1. What are the current sources of assistance used by older adults who are faced with mental or emotional problems?
2. What are the factors which influence utilization of mental health services by older adults?
3. Can the utilization factors that are controlled by the service delivery agency be used to determine acceptability of services?
4. What are the preferred sources of assistance of older adults?

For the purpose of establishing construct validity, the following hypotheses were tested:

H_1: The young-old, those individuals between the ages of 55 to 74, have a higher preference for formal services classified as having low acceptability than will old-old, those individuals 75 and over.

H_2: Services classified as having high acceptability will be preferred over services classified as moderately acceptable which will be preferred over services classified as having low acceptability.

Significance of Study

There are many benefits to be derived from this study. These benefits include establishing guidelines for appropriate service delivery methods as a means of preparing for

the anticipated increase in the mental health needs of this group (Eisdorfer & Lawton, 1973). Identification of factors associated with utilization of services will generate data for policy planning and allocation of resources, and it will provide a more comprehensive model for the systematic identification of factors influencing utilization of mental health services which may be used to improve mental health service delivery to this group (Select Committee on Aging, 1979).

Meeting the mental health needs of the current and the future older adult in our society is mandated both legislatively and ethically. In 1965, the Older Americans Act was passed with the stated purpose of providing "the best possible physical and mental health which science can make available and without regard to economic status" (Administration on Aging, hereafter referred to as AoA, 1979, p. 2). Ethically, counselors as represented by the American Personnel and Guidance Association subscribe to a code of ethics which states, "Members are dedicated to the enhancement of the worth, dignity, potential, and uniqueness of each individual" (Tolbert, 1978, p. 384).

In addition to meeting these obligations, it is probable that the mental health of older adults will result in decreased institutionalization (Myers & Drayer, 1979; Kahn, 1975; Markson, Levitz, & Gognalons-Caillard, 1973), and improved life satisfaction throughout the life span (Kurtz & Wolk, 1975).

The second area of benefit will be the generation of

data to aid policy decisions. Need for data regarding the most effective methods of mental health service delivery has been noted by a number of authors (Gaitz, 1979; Santore & Diamond, 1974; Schmidt, 1976; Bourestom, 1970; Adams, 1980; Kelman, 1980; Walders, 1981). As noted by Myers, Murphey, and Riker (1981) in a time of limited federal dollars, it is important to allocate scarce resources into the most effective and efficient programs.

The need for alternative means of mental health service delivery has been suggested by Gaitz (1979), Kahn (1975), and Walders (1981) among others. Avant and Dressel (1980) as a result of their survey, specified the problem when they said,

> In general, the public agency personnel usually opted for recommendations which solved problems with direct services, while respondents from the residential target sample heavily favored supportive, indirect services (p. 71).

The third area of gain is the development of a model for the systematic evaluation of factors influencing utilization of mental health services. It is apparent that factors influencing utilization of mental health services are many. These factors may be broadly classified as recipient factors, care-giver factors and milieu factors (Gaitz, 1974). There must be an awareness of need (Murdock & Schwartz, 1978) and ecologically appropriate services (Santore & Diamond, 1974). It is evident from the review of literature that extensive research has been done on the recipient factors and that there is need for mental health services. Myers (1978)

presents a very complete review of such counseling needs. Knight (1978) provides a review of the identified care-giver factors associated with utilization. However, the effects of the milieu and/or ecological factors is not clear. Defining these factors as characteristics of service provision which are culturally and environmentally acceptable, the available research supports the viability of this concept without providing much in the way of specific information as to the nature of these factors (Moen, 1978; George, 1981).

The influence of culture and the reluctance of the older adult to seek certain kinds of assistance has been noted by Adams (1980), Moen (1978), and Padilla, Carlos, and Keefe (1976) among others. However, these studies have two major shortcomings. One, studies which ask respondents for services which they have used or would recommend for use are limited by the extent of knowledge of community services on the part of the elderly. The second problem is with the studies which have asked for recommendations from a list of available services. These studies ignore the sources of assistance which may be preferred if available. Given the success of the many nontraditional mental health programs, it would be appropriate to compare preferences for these services to the use of existing services.

Limitations

The following limitations effect the generalizability of this investigation:

1. The reluctance of the older adult to admit difficulties with life events interferes with the collection of data by increasing the refusal rate and the item non-response rate.
2. This study does not attempt to include the isolated older adult who does not participate in community activities. Although these individuals may be the most in need of services, they represent a special class not appropriate for the general preventive orientation of this study.
3. This study is limited to groups of older adults who were participants in programs which serve the at-risk elderly.
4. The results of this study are only generalizable to the subjects who have similar characteristics.
5. The reliablity of the conclusions reflects the limitations of the survey instrument.
6. There is no attempt to validate the assumption equating preferences with actual help-seeking behavior.
7. This study suffers from the lack of power to randomize selection of subjects.
8. "Risk of improper interpretation is an inherent weakness in descriptive studies (Kerlinger, 1973 p. 390)."
9. The inability to control confounding variables is a limitation of the descriptive design.

10. The uniqueness of the target population prevents generalization to any other group.

Definition of Terms

For the purpose of this investigation, the following terms and definitions are employed.

Traditional Mental Health Services: Any agency or institution which has a stated purpose of providing counseling or therapy services to the elderly and is institutionalized in the community, i.e. funded on a regular, continuing basis.

Nontraditional Services: Projects which state as a purpose, the delivery or counseling or support services to the elderly and are not institutionalized, i.e. are funded on a temporary basis by state, federal or local agencies or private organizations.

Sample Coverage: Sample coverage was defined as the number of sample elements contacted from among the total estimated at-risk population in Pontotoc county.

Completion Rate: Completion rate was defined as the number of correctly completed questionnaires received from among the subjects contacted.

Response Rate: Response rate was defined as the total number of volunteer participants from among the individuals contacted.

Interviewer Variability: Interviewer variability was defined by Alwin (1978) as characteristics of the interviewer which may effect response.

Predisposing Variables: Predisposing variables were gender, race, age, education, and marital status (George, 1981).

Enabling Variables: Enabling variables were household income and living arrangement (George, 1982; Myers & Loesch, 1981).

Acceptability Variables: Acceptability variables were those factors identified by Moen (1978) which seemed to influence service utilization due to characteristics associated with the manner and method of service deliver.

Need Variables: Need variables were defined as mental or emotional concerns likely to increase service utilization.

Older adult: Older adults were defined as individuals 55 years of age and over as used by the Administration on Aging for program eligibility.

At-Risk Individuals: Individuals who possessed one or more demographic characteristics associated with high needs for mental health services were described as being at-risk.

Overview of the Study

Research has focused on the mental health needs of the older adult and some of the factors influencing the utilization of existing programs and services which are designed to meet those needs. However, only a small portion of the elderly utilize these services. Little research has been done on the cultural factors which influence this use. The

present study was designed to identify those factors associated with service utilization and develop an instrument which would assess the preferences of the elderly toward alternate forms of service delivery as well as traditional forms of service delivery.

The problem of identifying characteristics of the mental health service delivery methods which are most acceptable to the older adult was introduced in this chapter. The review of the literature associated with usage of mental health services is presented in Chapter II. The methodological procedures selected to implement the survey testing the characteristics of service systems are discussed in Chapter III. The results of this survey, the summary, conclusions, and recommendations are discussed in Chapter IV and V, respectively.

CHAPTER II

A SELECTED REVIEW OF THE LITERATURE

Introduction

The historical development of the mental health needs and problems of the elderly are outlined in this chapter. The chapter is divided into four parts: mental health needs of the older adult, factors influencing utilization of mental health services, a comprehensive model for assessment of factors effecting utilization, and the development of an instrument to evaluate the classification of the various methods of mental health service delivery.

Mental Health Needs of Older Adults

In 1900, the life expectancy of the average citizen of the United States was 49 years of age. By 1980, the life expectancy was 73 years of age (Subcommittee on Human Services, 1980). During the same period of time the percentage of individuals over the age of 65 went from 4% in 1900 to an estimated 11% in 1980 (Fowles, 1978). This shift in the age distribution of the population and the extension of the life expectancy of the individual presents unique problems to our human service delivery system. As the

Subcommittee on Human Services (1980) stated:

> This is of major social importance, although it is perceived as a private matter. Most of our social structures are actuarily based and, like Social Security, have been geared to a population that begins 'old age' at about 60, retires at 65, and dies at about 70 years of age (p. 9).

Society today is faced with numerically more adults over the age of 65, a greater proportion of older adults, and older adults who live longer than at any time in history. As noted above, these demographic trends have had a great impact on the individual and the human services delivery system.

Impact of Population Shift

Evidence of the new problems created by the shift in our population may be seen by examining the development of programs and services designed to serve this group. Prior to 1965, services to older adults were available from a variety of governmental agencies as part of a general social program. In 1965, the Older Americans Act was signed into law. This Act established the Administration on Aging (AoA) for the purpose of evaluating and coordinating programs related to older people and to "work with public agencies and private organizations to improve the lot of older people" (AoA, 1981, p. 4). As a result of this mandate, AoA developed a broad range of community services, education and training programs, and research efforts. Over 90% of the current AoA budget goes to community services. These services include services in the home, services in the

community, access services, and services to individuals in institutions (AoA, 1981).

Until 1974, mental health needs of the older adult were included in the community services component along with specific service areas such as transportation where relief of emotional stress or isolation was an incidental benefit. In 1974, however, the National Institute on Aging was established to focus research efforts on the "physical and mental health aspects" of aging (AoA, 1981, p. 7). There have been significant increases in knowledge as a result of these efforts. Services, however, have not expanded to address the particular mental health needs of the older population. Gold (1974) in describing services to the older adult identified the need for services to meet the special needs of older persons in dealing with changes brought about by aging. Padres describes these changes in his testimony before the House Select Committee on Aging (1979):

> The characteristics of aging for a large number of persons includes a high incidence of poverty, increasing susceptibility to debilitating physical disease, loss of status, and personal loss through death and disability (p. 43).

It is with these changes and services that this section is concerned.

Extent of Mental Health Needs

Older individuals who need mental health services may be divided into two groups: those with chronic or severe mental impairment and those with acute needs related to a developmental or situational crisis associated with aging.

Individuals with chronic or severe mental health problems are most frequently served through the public and private mental health clinics and hospitals. In 1975, individuals over the age of 65 accounted for 9.8% of all admissions to state and county mental hospitals and 25% of admissions to private mental hospitals (Rosenstein, 1980). According to the estimates of the Federal Council on Aging (1981), 56% of the elderly in nursing homes are there with a diagnosis of chronic mental conditions or senility, and 16% of these residents have a primary diagnosis of senility. Yet, according to Padres (Select Committee on Aging, 1979) 60% of the elderly admitted to state mental hospitals have never received previous treatment. Butler (Select Committee on Aging, 1979, p. 22) during his tenure as director of AoA, estimated that over half of these admitted patients are there because of an incorrect diagnosis of senility which may be corrected with "prompt and accurate diagnosis and treatment." This estimate is supported by a study of elderly new admissions to mental hospitals conducted by Markson, Levitz, and Gognalons-Caillard (1973). They concluded that two-thirds of the elderly admitted could have been treated elsewhere.

In addition to the unnecessary and tragic institutionalization of many older adults, the mental health needs encompass the unmet developmental and situational crises of this age group. Lombana (1976) suggested preventive counseling services should include preretirement, health, leisure, educational, and family programs. Blake (1981) in his

analysis of the rehabilitation needs of older adults identified the loss of spouse, the loss of employment, the loss of peers, the loss of good health, and the loss of self-reliance as common experiences faced by this group. In a survey of the major psychological problems of the Indian elderly, the National Indian Council on Aging (1981) identified chronic physical illness, need for institutionalization, financial needs, health and homemaker needs, and depression as the five most pressing problems. Disorientation was eighth, and alcohol abuse was ninth. While data on the actual number of older adults needing mental health services for acute or developmental problems is not available, there have been a number of estimates. Butler and Lewis (1982) believe that as many as 25% of the older population may need mental health services. Neuhaus and Neuhaus (1982, p. 103) estimated at least 3 million older persons need mental health services and another 7 million "live below or near the poverty level in social and environment conditions that contribute to emotional stress and breakdown." This coincides with the estimate of Harris (1978) following the national survey conducted by his organization for the National Council on the Aging (NCOA).

While these estimates identify a large number of older adults possibly in need of mental health services, Abrahams and Patterson (1978, p. 2) as a result of their survey in New England concluded that all surveys underestimate the prevalence of needs "due to the difficulty in reaching the

most isolated and alienated people."

Other evidence of the mental health needs of this age group includes external indicators of need such as the high suicide rate for older white males (Miller, 1978), the increasing evidence of elder abuse (Block & Sinnott, 1979; Franklin Research Center, 1980), and the increasing number of older adults institutionalized for mental health reasons (FCOA, 1981). The most comprehensive study of self-reported need for service is that of Myers (1978). Using the Older Persons Counseling Needs Survey, she found both a high level of comprehensive needs overall and particularly strong needs expressed by minority, low income, and low educational level individuals (Myers & Loesch, 1981).

Evidence of need may also be seen in the increasing number of reports of new programs designed to meet the needs of the older adult: displaced homemaker services (Friedrichs, 1982), widowhood programs (Golan, 1975), counseling for the seriously ill and their families (Garrett, 1978; Pilsecker, 1975), programs for nursing home residents (Kartmen, 1980; Linsk, Howe, & Pinkston, 1975), marital stress (Karson & Karson, 1978), adult education counseling (Porter, 1970), developmental groups (Reiter & White, 1978; Salmon, 1981; Water, Fink, & White, 1976), public housing (Stevens, 1973), and retirement (Wolfe & Wolfe, 1975; Johnson & Riker, 1981a). This is not meant to be a comprehensive list, but rather a suggestion of the type of programs currently available which are designed to address the

developmental or situation-specific needs of older adults.

Mental health needs, then, may range from the need for professional treatment for a severe and/or chronic condition to minimal intervention provided by a self-help group. However, only a small percentage of the older adult population actually receive any form of assistance. While data was not available on the number of individuals served through the more informal methods such as self-help groups, these programs are not widely available. Estimates of use of formal mental health services have ranges from 2% (George, 1981) to 4% (Select Committee on Aging, 1979) of all services being received by the elderly. A few self-reports of use, as will be seen later in this chapter, confirm these estimates.

Therefore, despite the mounting evidence of mental health needs, the utilization of mental health services was far below what might be expected. Not only do older adults use mental health services less than expected given the conditions associated with aging, they used these services proportionately less than the general rate for the population as a whole (FCOA, 1981). As a group, older adults have greater environmental stress (Select Committee on Aging, 1979), account for a disproportionate number of suicides (Miller, 1978), regularly experience a number of the most stressful of life events (Elwell & Maltbie-Crannel, 1981), and account for only 4% or less of the clients of formal mental health services.

Factors Influencing Utilization of Services

Factors influencing utilization of services in general and mental health services in particular are many. The most difficult problem in this area is the lack of a comprehensive theoretical framework in which to analyze the multiple factors influencing utilization. George (1981) in her secondary analysis of a survey of well-being conducted in Cleveland, developed a partial model. She described factors influencing utilization as being a function of three classes of variables: Predisposing variables, Enabling variables, and Need factors. Need factors are described as the measures of mental and physical health including impairments, self-rated health, number of chronic diseases and other factors as measured on the OARS Multidimensional Functional Assessment Questionnaire. Predisposing variables are described as demographic and social characteristics that relate to service need and service utilization including gender, race, education and marital status. Enabling factors are described as economic and social support variables which facilitate service utilization including household income, health insurance coverage, and perceived financial resources; and social support measures such as amount of interaction with friends, relatives, quality of this interaction and trust in the dependability of these resources. While George used these factors to predict type of personal care service provided, this model will also serve to examine

the source of mental health service provider.

Generational Factors

However, the model does not take into account additional factors which appeared in the research. Using what Bengtson and Kuypers (1971) call cross-generational perceptions, the model must take into account the cultural difference between service providers and recipients of service. Bengtson and Kuypers (1971, p. 249) argue that "the individual's personal history, his position in society, and his state of development subtantially color his perceptions and expectations of the other generations." The authors suggest that the fear of loss mythology and the developmental stake mythology are the subjective roots of generational perceptions. The fear of loss myth is described as a view of the young as social heirs and as an extension of the self; the validation of values and strategies. The developmental stake myth is described as the need for meaning, justification and validation in the life of the individual. Central to their argument is the issue of control and influence with the middle generation exercising control to reduce loss of status while the young desire control to reduce loss of independence. Although this study focused on the differences between young and middle-aged, it would appear to be valid for older generations. In a study of cultural discontinuity Robin (1971) reviewed studies which focused on generational differences in behavior and attitude. She

concluded that research was needed to separate cohort differences from developmental effects.

By isolating and focusing on the social characteristics of the older population, one can begin to identify those characteristics which contribute to nonutilization; factors which do not predispose the older adult to use existing services.

Individual Perceptions

Moen (1978) conducted a study of the methodology of needs assessment for the purpose of identifying factors which effect utilization. Concerned about the low reported service utilization of elderly rural residents despite the high level of needs perceived by outreach staff, she conducted a series of in-depth interviews with older respondents, and shorter interviews with service providers of various senior citizens programs. She developed an acceptor to non-acceptor continuum. She describes the non-acceptors as individuals who refuse to use service for which need is expressed or those who deny acceptance of assistance actually given. She explains this non-acceptor syndrome in terms that may be grouped as: (1) attitudes towards service organizations, (2) the relative perception of need, (3) the striving for independence, and (4) the lack of knowledge about services. Lack of knowledge about services is a common problem in human services, but for the older adult it is particularly acute when the individual must justify time,

energy, and cost of dealing with a social agency when the benefits to be received are unclear. Relative perception of need as used by Moen is a direct reference to the cohort differences among age groups. As Moen indicates, what is an acceptable level of income for a person who raised a family during the depression is often unacceptable to the middle-aged service provider. A research study conducted by Blazer (1980) suggests a similar difference in the attitudes towards stress. In his study of life events and health care seeking behavior, Blazer (1980, p. 1178) said that the older adult with "the expectation of certain changes in late life" may be better adapted to the stresses of later life. Blazer suggested that the weighting of life events on the Social Readjustment Rating Scale by Holmes and Rahe which was determined from studies of the general population, may not apply to the elderly.

The last two characteristics of the non-acceptor as identified by Moen (1978) are personal attitudes of the respondent population. One, the striving for independence, is mentioned frequently in the literature on adult development. Benedict and Ganikos (1981, p. 11) wrote, "To many older people, seeking help connotes loss of independence." Several authors described the need for self-sufficiency (Abrahams and Patterson, 1978; Buckley, 1972). McCaslin (1975) in her survey of a large city client group found Whites especially reluctant to admit need. Brill (1978, p. 191) in her discussion of dependency pinpointed the problem when she

said, "There is something shameful in admitting that one is incapable to dealing alone with the demands of living."

Karls (1978) in a survey of mental health professionals reported that these directors, supervisors, and staff frequently cited the reluctance of the elderly to admit mental problems and the labeling effect associated with receiving care as possible reasons for the low level of services. Knight (1978-79) reported the same response from therapists.

The last item, attitudes toward service organizations, refers to the hostility expressed by many older individuals towards welfare or welfare-type programs. Moen (1978) explained what she identified as hostility toward welfare in terms of cohort analysis. Based upon her analysis of events that occurred during the life time of today's older populations, Moen (1978, p. 298) said, "Older people may find it difficult to adopt ideas which appear to demean or devalue their roles as workers." As Stensrud and Stensrud (1981), Seligman (1975), and others have pointed out, service agencies and techniques of service provision may lead to a sense of powerlessness. Bengtson (1973) in an extension of his generational theory identified this as the need for "effectance" or the need to have some sort of influence on environment. Lehtinen and Vaisanen (1978) provide support for this concept from a general population survey in Finland. They found that respondents most in need of mental health services as determined by others showed the more negative

attitudes toward such services while those who determined their own need showed more positive attitudes. Self-determination, control of self, may then be the underlying root of hostility towards services of any sort. Weber (1973, p. 65) in his discussion of mental health services for the older population speculated that "The perception of the participant is a powerful determinant of the utilization of services." He continued by suggesting that it is probably most critical in the initial phase of service delivery.

Factors Associated With Service Delivery

If there is an underpinning of fear of loss, fear of powerlessness, and striving for independence, what are the charactistics of acceptable services? Based upon her survey Moen (1978) suggested the following criteria for the range of services acceptable to the older population. Most acceptable were those services which were perceived of as earned such as Social Security, pensions, and/or services previously paid for by taxes. Mutual assistance services were next on the continuum. These included aid from family and friends which the recipient could repay or reciprocate at some other time. Programs based on age eligibility and available to all were third. Moen suggests that these services are seen as prepaid - that these services are paid for by previous tax payments or given by society as a reward for years of work. The last two categories were those services which required either age and income eligibility or solely income elibibility. When the perception of service

was such that the service was seen as being for the poor it was most unacceptable. If the program was seen as one primarily for senior citizens it was somewhat more acceptable. Support for this acceptable to unacceptable service continuum may be gathered from a number of other studies, particularly those studies which deal with the minority elderly.

Studies of minority elderly are important for two reasons. First, the quality and quantity of these studies are somewhat better suited to this project than those which have focused on the general population. Secondly, several of these studies suggest that age rather than ethicicity is the most important influence on utiliation. Therefore, age cohorts may be more homogenous in attitudes and utilization patterns than ethnic cohorts. Several of these studies will be examined in detail.

Adams (1980) conducted an extensive study of service arrangements preferred by a sample of minority elderly in San Diego. Using network sampling procedures, minority elderly were asked what types of service arrangements they preferred for selected areas of need. Service arrangements were grouped according to type of service provider: intimate (myself or family), informal (friends and/or neighbors), and formal (professionals and/or agencies). Overall, all ethnic groups preferred intimate types of arrangements as a first choice; informal arrangements were second; and formal services were third. Adams did not include any forms

of earned assistance services as defined by Moen (1978) in his list. The needs selected by Adams included, medical care, transportation, minor financial, major financial, counseling, physical help and food. The need for counseling services and the pattern of preferred service arrangements did not exhibit any differences by the three ethnic groups in the study. Counseling services, defined as who do you turn to or talk to, were preferred from intimate (60.2%), informal (25.3%), and formal (11.1%) service providers, respectively.

In a study of Mexican Americans in Los Angeles, subjects were asked where a person with an emotional problem should go for help (Padilla, Carlos, & Keefe, 1976). In order, the replies were doctor (25%), relative (20%), priest (17%), friend (14%), professional (9%), and mental health clinic (4%). Professional services were recommended more often when the specific problems of suicide and "bewitchment" were presented. Alcoholics Anonymous and drug abuse clinics were the most recommended for alcohol and drug problems. This study also tested for knowledge of mental health services and found younger respondents (under 35) more knowledgable than those over 35. Testing for mental health resources used by subjects during the previous year, the researchers found relatives used by 36%, friends by 26%, doctors by 21%, priests by 16%, community workers by 9%, and groups by 7%. Private professionals, mental health clinics, and other agencies were used by 4% or less. The authors, as a result

of the in-depth interviews, concluded that lack of utilization of mental health services was not a result of lack of knowledge nor a negative attitude toward services but was a preference for alternate resources available in an informal network of support.

In a study of users of mental health services in Los Angeles, subjects which used a mental health service were asked where people in general sought help (Moll, Rueda, Reza, Herrera, & Vasquez; 1976). Forty-six percent of these consumers of mental health services recommended the mental health agency (reflecting their status as clients), 17% suggested relatives, and 10% a doctor. Twenty percent suggested other sources. However, this study also asked how consumers had made contact with the agency. Fifty-one percent of subjects were referred by another agency, 26% were referred by family or friends, 18% by a private physician, and 5% were self-referrals. The agencies most responsible for referrals were a medical center complex and a county welfare office. Respondents were also asked sources of prior information regarding the mental health clinic. The results were: 21% from television and 9% from community meetings and/or newspapers.

Another study conducted by Fandetti and Gelfand (1978) focused on Italian and Polish neighborhoods in Baltimore. Using vignettes depicting individuals with various emotional problems, subjects were asked to recommend initial sources of assistance and intensive sources of assistance for each problem. The extended family was most preferred for initial

assistance regardless of problem. Local sources of assistance such as priests, doctors, friends, etc., were second. Third were the specialists. Specialists, either agency or individual, were recommended over other sources of assistance only for schizophrenia and alcoholism. The family doctor was the next most frequent recommendation for intensive help. Using a sample between the ages of 21 and 50 years of age, the team found significant differences between older and younger subjects on the use of family and local resources for both initial and intensive assistance as opposed to use of specialists. Each succeeding generation was more willing to use outside resources.

In a similar study, Abrahams and Patterson (1978-79) found community services used by 9% or less of all respondents. Highest utilization was reported for physicians (12%) and friends or relatives (10%). Forty-six percent of subjects identified as depressed reported receiving no help.

Additional Factors Associated With Utilization

Other studies which have focused on utilization factors for various social services have reported additional factors. In a study of attitudes towards doctors and help-seeking from physicians, Nuttbrock and Kosberg (1980) found the perception of physician as being interested in the welfare of patients to be more important than ratings of technical competency or performance in predicting help-seeking

behavior. Using a subsample of 122 respondents 60 years of age or older from a primary study of public evaluation of physicians, the authors found physician affectivity associated with both the inclination and actual behavior of seeking a doctor's help.

Robertson (1978) identified the conflicting research data regarding types of support systems desired by the elderly and the activity patterns associated with various systems. Her study drawing on a sample of older adults, examined preferences for four types of activity: family, friends, organizations, and work. Preference was operationally defined as desire for social participation and/or group membership in each type of activity. She found that preference for family activity patterns increase from the 40's through the 70's. Friendship activities gradually decrease, and organizational and work activities remain fairly constant. There was a decrease in all types of activities for the age group over 80. When Robertson examined the relationship between a life satisfaction score and activity patterns, she found a positive relationship between the amount of activity in friendship and organization and life satisfaction but no relationship with amount of family activity. She concluded by saying:

> One of the most significant pieces of information this data points to is the value of friendship activities in adult life and the need for professionals to develop services that put older individuals in touch with their peers (p. 105).

Others have noted the role of friendships. Lowenthal and Weiss (1976) examined the need for research regarding the role of intimate relationships as a psychological resource in transactions and crises of the adult life course. Miller (1978) in his study of geriatric suicide found that men who died of natural causes were more likely to have had a confidant than were the suicidal men. Three-fourths of the men who killed themselves had visited a physician within a month of death, and 60% had presented clues to relatives, friends, and physicians. Miller (1978, p. 494) said, "The lack of, or loss of, a confidant in late life seems to predispose some older people to suicide."

A 1978 study by Hanssen, Meima, Buckspan, Henderson, Helbig, and Zarit was designed to investigate the differences in Senior Center users, former users, nutrition project only participants, and persons who had never participated. Using selective samples from each group, the study found differences among groups based on health, affective status and life style. Combining the two user groups, 56% of participants and 43% of former participants indicated attendance was based primarily on the desire to socialize. Without supplying the data, the authors suggested having a friend who was a participant seemed to make a difference in becoming a participant.

A number of authors have cited various other factors influencing utilization. Kethley and Herriott (1980) focused on the inability of the mental health system to

provide the outreach effort necessary to locate elderly individuals in need of services and proposed a shared needs assessment with the aging network to correct this problem. Lack of access to services and the level of effort required to locate and facilitate contact between those in need and service providers was also noted by the President's Commission on Mental Health (FCOA, 1980). The need for personal contact by service providers may also reflect the problems created by the literacy skills of older adults. Studies reported by the National Institute on Aging (1980b) suggest that older people have difficulty completing the forms required by many formal service delivery agencies.

Reluctance of the care-giver to treat the elderly has also been frequently mentioned (Knight, 1978-79; Garfinkel, 1975; Kahn, 1975). Patterson (1976, p. 271) after his evaluation of eight community mental health centers, concluded that most centers neglected the older adult because, "Negative attitudes toward the elderly and a false belief that most psychiatric conditions in the elderly are untreatable". Garfinkel (1975) surveyed the attitudes of mental health professionals in a New York hospital and found that most agreed that the elderly did not talk. He suggested that the denial of the need to talk may result in different expectations for theraputic outcomes and influence the utilization of mental health facilities by the older adult. However, in a comparison of anticipated barriers and actual barriers encountered, Pratt and Kethley (1980) found that

while 60% of the staff anticipated the attitudes of the older adult to be a problem, only 30% of the staff reported actually encountering negative attitudes. Referring to the study of perceived affectivity as an important predictive variable (Nuttbrock & Kosberg, 1980), this would then suggest that mental health care-givers may not be perceived as being interested in the welfare of the elderly. This may not be a reflection of negative attitudes toward the older individual per se, but may rather be, as Kahn (1975) suggests a reaction to the older adult's unwillingness or inability to respond to the usual verbal psychological treatments.

Model for Assessment of Factors Influencing Utilization

Returning to the classification system suggested by Moen (1978), these studies support the acceptable-nonacceptable continuum. Least acceptable program characteristics were income or income and age eligibility. If the program was perceived as one primarily for senior citizens, its acceptability was improved. Formal services which generally require income eligibility and/or a formal statement of need were the least recommended services in the studies by Adams (1980); Padilla, Carlos, and Keefe (1976); Moll, Rueda, Reza, Herrera, and Vasquez (1976); Abrahams and Patterson, (1978); and Fandetti and Gelfand (1978). The second area of acceptable service was the characteristic of age eligibility. No study directly measured the acceptance of senior citizens

programs compared to general community services. The next level of acceptability was characterized as mutual assistance such as aid from family or friends. Again, intimate and informal forms of assistance (Adams, 1980); relatives, priests, and friends (Padilla, Carlos, & Keefe; 1976; Moll, Rueda, Reza, Herrera, & Vaquez; 1976); and extended family assistance (Fandetti & Gelfand, 1978) were most frequent recommendations. Doctors which were recommended sources of assistance in all of the above studies present a special case. In the study by Adams (1980) doctors were considered a formal service. In the studies of Mexican-Americans, doctors were not considered a formal service. Fandetti and Gelfand (1978) considered the physician a form of local assistance. It could be argued that assistance from doctors may be seen as a form of earned assistance since for most elderly this assistance would be paid for under health insurance which is considered a prepaid assistance. Also, many elderly have a "family" physician who is thought of as a friend. Therefore, if doctors are classified as a form of mutual or earned assistance, no form of service exhibiting the unacceptable characteristics described by Moen (1978) received more than 11% of the recommendations of any group studied.

Attitudinal Factors

Shifting to the attitudes of the nonacceptor of service, who was characterized as striving for independence and hostile towards welfare type service organizations, the

other research studies identify the fear of loss (Bengston & Kuyper, 1971), perception of caring (Nuttbrock & Kosberg, 1980), and preference for family activity (Robertson, 1978) to be important factors influencing utilization. Suggestions of learned powerlessness (Stensrud & Stensrud, 1981) and the reluctance of care-givers to serve the older adult (Kethley & Herriott, 1980; Knight, 1978; Kahn, 1975) were also made. The President's Commission on Mental Health addressed this issue when it said:

> Central to the maintenance, protection and improvement of the physical and mental health of the older population is the enhancement of the individual's own capacity to cope with the aging process and to understand the factors which can enhance . . . or inhibit . . . the quality of one's own life (FCOA, 1980, p. 47).

The Commission continued in its report by recommending a public education campaign as a collaborative effort between mental health centers, the aging network, and senior citizens organizations. It was recommended that this campaign include many educational techniques directed to both the older adult and the families of older persons. Similar recommendations were made by Abrahams and Patterson (1978), Avant and Dressel (1980), Myers and Drayer (1979), Gaitz (1979), and Gold (1974). The study by Avant and Dressel (1980) addressed the problem of different perceptions of needs by the elderly versus the service provider. Based on their review they suggested that:

> Public agency personnel usually opted for recommendations which solved problems with direct

> services, while respondents from the residential target sample heavily favored supportive, indirect services (p. 71).

While increasing the functional ability of the individual directly relates to the striving for independence, the other aspect of this attitude is the fear of loss and stigma of illness, mental or physical. This has also been frequently mentioned in the literature. Khan (1974) suggested that for minority groups fears of psychiatric care and hospitalization may be acute. Gertz (1975) found this general attitude reported as the third prevelant problem by rural community mental health centers. A source of this fear is suggested by the National Institute on Aging (1980) in its report on senility which describes the confusion between emotional problems and irreversible brain disease. Butler and Pardes (Select Committee on Aging, 1979) also noted this confusion between mental and physical health problems.

Lack of knowledge of services was the last item suggested by Moen (1978). Little research is available on the general knowledge of services available. However, a study by McWilliams and Morris (1974) indicated that one-half of their sample had prior knowledge of the local community health center. However, Murdock and Schwartz (1978) interviewed 160 Native Americans and foreign respondents whose lack of unawareness of services exceeded 40% for 15 of the 21 agencies identified.

Service Delivery Factors

Returning to the work by George (1981), it was suggested that the additional class of variables be added to her model of service utilization factors. This class of variables would include the factors which effect the perception of acceptability for the method of service delivery. These factors are:

1. The capacity of the service to enhance the self-reliance of the individual as opposed to providing a service to the individual.
2. The capacity of the service to enhance mutual assistance programs.
3. The capacity of the service to enhance the informal helping network of the individual.
4. The capacity of the service to provide a structure of policies and procedures which avoid formal means tests and/or formal declaration of dependency.

Using the model factors contributed by George (1981), the model would now consist of these elements: Predisposing variables (demographics); Enabling variables (economic and social support); Need factors; and Acceptability of service delivery variables.

While there is not direct research evidence for this last class of variables, there is support for it in the success reported by nontraditional programs which meet the above criteria. An examination of services available to

widows and widowers illustrates this statement. The resources available to the older individual who has lost a spouse range from individual therapy available from mental health centers or private mental health specialists to self-help groups such as the Widow-to-Widow program sponsored by the American Association of Retired Persons (AARP). In addition to these services, individuals may seek out family, friends, clergymen, or others. There are a number of books and articles available on grief and loss (Kubler-Ross, 1975; Jackson, 1957). Articles frequently appear in newspapers, magazines, etc. These services may all be classified as resources for assisting the individual in coping with the loss of a spouse or other loved one. Rating the acceptability of these services according to the criteria developed would produce:

1. Least acceptable-mental health clinics and mental health specialists.
2. Moderately acceptable programs - AARP group.
3. Most acceptable services - books, articles, television programs, etc.

It should be noted that while the AARP program is assigned to mutual assistance, other groups which did not require a formal declaration of emotional need might be assigned to the most acceptable category.

The point is made by George (1981, p. 4) when she says, "Some services are tied in obvious ways to particular providers, but many services are potentially available from either formal or informal care-givers."

Appendix A provides a comprehensive model for identifying and classifying these factors. The fourth class of variables are those factors associated with the perceptions of the service as being acceptable. For the purpose of this investigation, these factors were labeled Acceptability variables.

Instrument Development

The need for research into service delivery methods has been noted by Walders (1981), Sargent (1980), Gaitz (1979), and Patterson (1976). The need to consider cultural characteristics, particularly for the minority elderly, has been suggested by Abad, Ramos, and Boyce (1974), and Adams (1980). Specific recommendations of various nontraditional services have been made by Hickey (1969), Santore and Diamond (1974), Patterson (1976), Malone (1979), Kelman (1980), and Dunn (1981). Research evidence confirms the nonacceptable status of many existing services. However, there is no research evidence regarding the acceptability factors as used in the classification model.

Problems With Existing Instruments

In order to examine the acceptability of nontraditional methods of service delivery, it is necessary to compare these forms of service to the more traditional service arrangements. Survey instruments used in the research previously cited present two problems. First, only the studies

which have used the OARS (George, 1981; Blazer, 1980) have any data supportive of the survey instrument itself. Since the purpose of this study was to delineate the factors effecting utilization of mental health services by the older population, it was important to have standardized, valid and reliable data-gathering procedures (Isaac & Michael, 1977). As Gay (1976) points out, validation of the questionnaire in descriptive research is often neglected. Alwin (1978) discussed the need to reduce errors in data collection through improvement in theoretical and conceptual formulations and improved methods of sampling, questioning, and interviewing. Other sources of error, he maintains, are in the sample bias as indicated by response rates and method of administration. Kerlinger (1973) recommends checks on the validity and reliability of the survey. No survey instrument used to identify resource utilization patterns has, or has reported, the data necessary to determine validity, reliability and/or possible data collection errors. The OARS instrument which has been extensively developed contains only a small subsection on resource utilization since it is primarily a measure of mental and physical functioning.

The second problem presented by the existing studies is the lack of consistency in question structure. The studies by Moll, Rueda, Reza, Herrera, and Vasquez (1976); Abrahams and Patterson (1978-79); and Fandetti and Gelfand (1978) asked respondents what services they would use given a specific problem or what services they had used in the past.

The studies by Adams (1980); Padilla, Carlos, and Keefe (1976); and Murdock and Schwartz (1978) asked respondents to select from a predetermined list. The first method is limited to the types of resources of which the respondents have knowledge. It is also colored by the misinformation and misperceptions of the respondents toward the service in question. The second method may also be influenced by misperceptions and misinformation, and it is limited to the resource as identified by the professional. As the study by Avant and Dressel (1980) suggested, the perceptions of appropriateness is different for consumer and practitioner.

This lack of standardization confuses the issues regarding service utilization. As may be seen in the comprehensive model of assessment, there are many factors involved in service usage. Only by identifying and assessing the impact of separate elements can a truly useful criteria for maximizing service resources by developed.

Therefore, the third item which supports the development of a standardized survey instrument was the need to assess the impact of the variables labeled "Acceptability." Given the indirect support for this factor that is evident in previous research it would seem logical to begin with acceptable services before assesing the impact of factors beyond the control of the service providing agency such as those labeled predisposing and enabling.

As a final point, this researcher would suggest we consider the questionable practice of reporting data from

unsubstantiated instruments regarding topics of programatic concern. For example, attitude instruments which are the subject of much debate, are rarely used to plan allocation of money into services are developed with great care. Surveys attempting to identify why the elderly do or do not use a given service and which have the potential to alter the way resources are allocated are not reported with the same amount of care. Whether these instruments are developed with the same care is not known.

Summary

As noted, the types of assistance preferred by the older individual remains remarkably consistent regardless of age, race, and/or type of measurement used. However, the type and amount of indirect assistance received and preferred by the individual is not known. Given the limitations of repeated measurement of the preference of the individual for current formal services, it is logical to now expand the inquiry in the area of projected services. Going beyond a simple survey of preference for currently available resources, it is necessary to heed the cry of gerontologists and assess the usefulness of other types of services.

New and innovative service delivery systems may be tested in a number of ways: (1) model projects, (2) examination of consumer initiated services, and/or (3) research studies. While consumer initiated services are a continuing source of direction for human services, the unique factors

which contribute to the success or failure of these projects make them rather difficult to duplicate and hence to institutionalize. Demonstration projects are a favored method of testing new ideas, particularly with practioners. However, as can be seen from a review of federal grant activities, many of these ideas are not based on research evidence nor are they well conceived methologically. Second, many model projects which are funded are not continued, not due to lack of success but due to lack of funds. Given the particular economic climate today, it is likely that even fewer projects will be funded, and fewer still will be continued. The third method of assessing innovations is systematic research. The testing of the idea via research is both more systematic and cheaper than assessing a number of different projects with different clientele and different evaluation data. Research of this type may be used to generate data which may be used to identify the most likely direction for service delivery. Policy decisions may be made in the area of model projects, and continual support for programs and/or activities which show promise. It was for this purpose that this study was undertaken. Hyman (1955) describes the role of the experimental survey as a test of some specific hypothesis. Stated in general terms, then, the focus of this study was to identify the characteristics of various forms of service delivery which influence the acceptability of that service to the older adult. Specific hypotheses and the procedures for testing them are detailed in Chapter III.

CHAPTER III

DESIGN AND PROCEDURES

Introduction

Discussed in Chapter III are the design of the study and the procedures used to develop and examine the validity of the study. The chapter is organized in the following manner: research design, sample selection, instrument development, method of data collection, the analyses of the instrument, and the analyses of the data collected.

The methods and procedures discussed in the following sections specifically address the design of the survey instrument used to assesss the preferences of older adults. The methodology used to examine the survey procedures and the data are also presented.

Research Design

Once the factors which were under the control of the service delivery agency which seemed to effect utilization of services were identified, a method of assessing the preferences of the older adult was needed. Therefore, a descriptive study was chosen as the method of assessing the preferences of older adults for various forms of mental health services. This design was chosen to gather initial

data regarding the preferences of the older adult and the usefulness of the identified service utilization factors.

Population and Sample Selection

The population in this study was the older (over 55) at-risk adult. The at-risk category included individuals with predisposing or enabling characteristics indicative of high service utilization such as low income level, membership in a minority group, marital status, living arrangement, age, sex, and level of education. Limitation of the target population to the narrowly defined at-risk older adult was done for two reasons. First, as Hyman (1955) points out, it allowed for control of certain extraneous variables. In the case of this study it was control for the factors classified as predisposing and enabling. The individuals in the intact groups contacted on behalf of this study represented a large pool of individuals with the characteristics reported to influence service utilization.

The second reason for limiting the sample to those at-risk individuals was to maintain the usefulness of the study to program planning. It allowed for assessment of preferences of the population where the probable need for human services was great (Neuber, 1980), and followed the recommendations of the President's Commission on Mental Health and the Elderly (FCOA, 1980) which suggested using target populations consisting of those elderly in the community which can be reached through existing community organizations

where preventive programs would most likely be housed.

Therefore, groups selected for sampling included: congregate meal site participants, senior center participants, elderly housing project residents, and nonaffiliated older adults in nursing homes and in the community at large.

Similar sampling techniques were employed by Adams (1980) and Myers (1978). Lack of random sampling was defended by both authors on the basis of need to reach the most vunerable elderly. Adams (1980) described this sampling method as network sampling and suggested that it was more useful in the study of a population when communal conditions were the focus. As noted by the Federal Council on Aging (1980), it is the most likely manner of future service delivery in the area of mental health. Gay (1976) refers to this type of survey as a census survey.

Minimum Sample Size

Minimum sample size was estimated in the following manner: The total number of individuals over the age of 65 (N=3, 191) in Pontotoc County as reported by the Oklahoma State Data Center (DECA, 1981) was multiplied by the percent of elderly thought to be in need of services (25%) as estimated by Butler and Lewis (1982). The resulting estimate of adults in need of services was then 798. Ten percent of the target population was determined to be the minimal sample size (N=79). It should be noted that the estimate of 25% is higher than the estimate of need determined by Husaini and

Neff (1979). In this random sample survey of the mental health needs of southern Oklahoma, the estimated percent of older adults in need of mental health services in Pontotoc County was approximately 20% on various measures of mental health well-being.

As Isaac and Michael (1977, p. 69) suggest, the exploratory research should be "large enough to test the null hypothesis yet small enough to overlook weak treatment effects." The purpose of exploratory research as they see it is to find promising leads. They recommend a sample size between 10 and 30 in order to avoid statistically significant findings which are not practically significant.

Description of Sample

The sample consisted of 141 volunteers from various community programs designed to serve this population and older adults contacted in the community at large. The demographic characteristics of those subjects who participated in the survey in any manner are shown in Table I. The distribution of the subjects among the various community groups was as follows: nutrition projects (N=88), senior center and housing programs (N=26), and nonaffiliated older adults (N=27), for a total of 141. Of the 141 individuals who participated in the survey, 85 correctly completed the questionnaire. This group constituted the subsample used for the analysis of the results. The entire sample was used and is further described as part of the analysis of the survey instrument in terms of possible sampling bias.

TABLE I

DEMOGRAPHIC CHARACTERISTICS

Variable	Completed Correctly		Partially Complete		Incomplete	
	Number	Adjusted Percentage[b]	Number	Adjusted Percentage[b]	Number	Adjusted Percentage[b]
AGE						
55-64	18	22.2	4	17.4	3	13
65-69	17	21.0	5	21.7	3	13
70-74	13	16.0	5	21.7	7	30.4
75-79	15	18.5	7	30.4	4	17.4
80 & over	18	22.2	2	8.7	6	26.1
[a]MV	4		2		2	
SEX						
Male	20	24.7	4	17.4	8	33.3
Female	61	75.3	19	82.6	16	66.7
RACE						
White	79	96.3	20	87.0	22	91.7
Indian	3	3.7	3	13.0	2	8.3
[a]MV	3		2		9	
MARITAL STATUS						
Not Married	5	6.1	0	0.0	1	4.0
Divorced	3	3.7	1	4.3	0	0
Married	31	37.8	7	30.4	9	36.0
Widowed	43	52.4	15	65.2	15	60.0
[a]MV	3		2		0	
INCOME						
0-$3,999	28	36.8	11	57.9	10	52.6
$4,000-$9,999	33	43.4	8	42.1	7	36.8
$10,000-$14,999	9	11.8	0	0.0	1	5.3
$15,000-19,999	3	3.9	0	0.0	1	5.3
$20,000 +	3	3.9	0	0.0	0	0.0
[a]MV	9		6		6	
EDUCATION						
0-6 Yrs.	8	10	5	21.7	2	8.7
7-11 Yrs.	31	38.7	8	34.8	15	65.2
HS Grad	18	22.5	8	34.8	4	17.4
Some College	11	13.7	2	8.7	1	4.3
College +	12	15	0	0.0	1	4.3
[a]MV	5		2		2	
LIVING ARRANGE.						
With Spouse	31	37.8	5	22.7	7	30.4
Alone	42	51.2	16	72.7	15	65.2
With Others	9	11.0	1	4.5	1	4.3
[a]MV	3		3		2	
EMPLOYMENT STATUS						
Working Fulltime	12	14.8	1	5.0	0	0.0
Seeking Work	2	2.5	0	0.0	0	0.0
Not Seeking Work	67	82.7	19	95.0	24	100
[a]MV	4		5		1	

[a]MV - Missing Values

[b]Adjusted Percentage - Percentages excluding Missing Values

The demographic characteristics of each subsample exceeds the proportions reported by DECA (1981) for females (61%) and for Whites (89%). The sample underrepresented minority members. However, as noted later there is the suggestion that respondents who would be classified as Indian did not identify themselves as such on the survey form.

Instrument Development

The instrument, Preferred Sources of Assistance Survey (PSAS), was constructed using the classification system described in Chapter II. Each class of variables was examined for pertinent items. Items were selected on the basis of reported frequency.

Current Sources of Assistance

Sources of assistance used by older adults were divided into three groups according to the methodology of the research study. These groups were: sources of assistance volunteered by the respondents in response to a stimulus problem, sources of assistance recommended by respondents from a list presented by the researcher, and sources of assistance reported as highly utilized and/or recommended by experts in gerontology. Sources of assistance volunteered by respondents in answer to a stimulus problem consisted of family, friend, family doctor, priest, nurse, police, and mental health specialists (Abrahams & Patterson, 1978;

Fandetti & Gelfand, 1978; Moll et al., 1976; Padilla et al., 1976). Sources of assistance selected from a list presented by the researcher in rank order were: family, friends, doctor, neighbors, professionals, and agencies (Adams, 1980; Moen, 1978; Murdock & Schwartz, 1978). Media programs, educational services, community groups, outreach services, senior center services, and theraputic workshops were recommended by the gerontological experts (Gaitz, 1979; Hickey, 1969; Isaacs, 1974; Kahn, 1975; Malone, 1979; Myers & Drayer, 1979; Patterson, 1976; Santore & Diamond, 1974).

Predisposing Variables

The investigation into current service utilization patterns identified certain characteristics of individuals which were reported to influence utilization. Using the service utilization model of George (1981), these factors were labeled predisposing variables. This category of variables included gender, race, age, level of education, and marital status.

Enabling Variables

The second class of variables found to influence patterns of service utilization were the enabling variables (those characteristics which enabled a person to avoid seeking outside help). These factors were household income and living arrangement (George, 1981).

Need Factors

Characteristics of individuals which were found to increase service utilization were labeled need factors (George, 1981). These characteristics included problems commonly encountered by older adults such as depression, anxiety, finances, family relations, employment, usefulness, retirement, suicide, death, and inability to use community services.

Factors Influencing Acceptability

The last class of variables included in the service utilization model were those factors identified by Moen (1978) which seemed to influence service utilization. Based upon the Moen's study and others, the following criteria were developed:

1. The capacity of the service to enhance the self-reliance of the individual as opposed to providing a service to the individual.
2. The capacity of the service to enhance mutual assistance between individuals.
3. The capacity of the service to enhance the informal helping network of the individual.
4. The capacity of the service to provide a structure of policies and procedures which would avoid formal tests of ability to pay.

Using these criteria, the following categories of acceptability were established. Group I services were sources of assistance which met all four of the above criteria such as help from family, friends, doctors, and clergymen. This category was labeled highly acceptable.

Group II services were those sources of assistance classified as moderately acceptable because the service required some declaration of need and was not necessarily mutually assistive, but did enhance the self-reliance of the individual. Examples of sources of assistance in this category are: reading a book, attending a meeting, listening to a lecture, and watching a television program. Group III (low acceptability) were services which required some form of needs statement such as admission of a problem, means test, etc.; were not mutually assistive, did not enhance the capacity of the individual; and services delivered in any formal agency setting and/or for which an application procedure is required. These included social services agencies, senior centers, nutrition projects, and mental health centers.

Once the comprehensive model was formulated, interviews with local older individuals were conducted for the purpose of assessing local differences in service utilization options (Edwards & Porter, 1972; Henerson, Morris, & Fitz-Gibbon, 1978). Questions from several of the cited research studies were combined into a short interview schedule (Appendix B). These interviews were conducted by a

senior level college student who was instructed in the interview format. Tape recordings were made of these interviews and analyzed for additional sources of assistance and/or problems. No new responses were received. It was concluded that the range of sources of assistance and problem types from the identified research was adequate for use with the local target population.

Construction of the Questionnaire

As Gay (1976) points out, descriptive studies generally seek information not already available and therefore require the development of an instrument. Self-report studies may use questionnaires or interviews. Consideration was given to each of these methods, and the forced-choice questionnaire was chosen for the following reasons. Questionnaires as opposed to interviews are more economical both in time and money (Henerson et al., 1978). Second, the use of the self-report questionnaire would reduce the threat of self-disclosure by the respondent (Alwin, 1978). Third, the use of the questionnaire permits wider application for future use. The questionnaire design may be used in needs assessment surveys (Mitchell, 1978) and other similar nonresearch purposes. Finally, the questionnaire design was chosen because the questions represented sensitive topics to many older people, and it was felt that the self-report would be less likely to produce socially acceptable response sets.

However, personal interviews generally offer a greater response rate (Warheit, Bell, & Schwab, 1979), and the reluctance of the older adult to participate in surveys is generally acknowledged by practitioners (Mitchell, 1978). Therefore, it was decided to combine the personal approach with the self-administered questionnaire (Henerson et al., 1979). This offered the advantages of reduced cost, increased opportunity to explain the purpose of the survey, and would also allow the researcher and the assistants to establish rapport with the older adults (Warheit et al., 1979). The PSAS was designed to be given to a group with individual assistance provided if needed.

Item Selection

Following the guidelines suggested by Gay (1976), the items and sources of assistance from the comprehensive model were combined into a list of factors to be included in the instrument. Items were included based upon the frequency with which they were reported in the literature. The identified items by class of variable from the model are shown in Table II.

The items listed as predisposing and enabling variables in Table I were combined into an eight item personal information sheet. Each of these demographic variables were assigned forced-choice responses based upon the data sheet used by Myers (1978). The classifications used in each demographic category reflects factors identified in the

investigation of the literature as having impact upon service utilization.

TABLE II

COMPREHENSIVE MODEL OF FACTORS AFFECTING SERVICE UTILIZATION

I. Predisponsing Variables	II. Enabling Variables
age race gender marital status level of education	family income living arrangement employment status
III. Needs	IV. Acceptability
grief dying physical aging suicide family relations usefulness finances inability to use community services	Group I High family friends doctor clergyman Group II Moderate self-help groups educational services Group III Low agency services

For the initial questionnaire 10 needs items (problem statements) and 13 sources of assistance (resources) were selected. The 10 needs items were selected to control for the possible interaction between the source of assistance selected and the type of problem encountered as suggested by the studies of several researchers (Adams, 1980; Fandetti & Gelfand, 1978; Padilla, Carlos, & Keefe, 1976). Therefore,

representative problems covering the range of needs were selected.

The sources of assistance were selected on the basis of previously stated acceptability criteria. In order that a complete range of assistance options would be available, equal numbers of services were listed in each category of acceptability (high, moderate, and low). Each item represented the most frequently mentioned source of assistance used or suggested by professionals in the field, except for items listed in formal services (low acceptability). Since there are limited resources available to the older adult, all local resources were used and identified by the common names given to the services in Pontotoc County, i.e., nutrition project, senior center, social services, and mental health center.

In order to account for the nonacceptor of service a fourth category was added to the source of assistance list (Moen, 1978). The item, Do Nothing, was included for those individuals who do not or can not utilize external sources of assistance. This may include the individual who will not seek outside assistance for a problem, and those who prefer passive responses such as praying, thinking about it, hope problem goes away, etc. (Husaini & Neff, 1979).

The next step was the development of the cover letter and the general instructions. Language and format followed that used by Myers (1978) since Myers' instrument had been analyzed for readability, and the format had been field

tested. The completed PSAS is included as Appendix C.

Scoring was based on an ordinal ranking scale similar to that suggested by Warwick and Liniger (1975). Respondents were told to select five preferred assistance items for each question. The first choice of assistance was to be ranked number 1; the last choice of assistance was to be ranked number 5.

Pilot Testing

A panel of judges was utilized to evaluate the face validity, format, readability, and clarity of instructions of the initial questionnaire (Henerson et al., 1978; Isaac & Michael, 1977). The panel included two mental health specialists in gerontology (1 Ph.D., 1 M.Ed.) two gerontological program directors (both M.Eds.), and two gerontological program outreach workers (1 high school graduate, one less than high school). The panel members were selected for their knowledge of and experience with older adults. Every panel member had some degree of direct service duties with older people.

The judges were asked to rate the questionnaire on readability, instructions, clarity, resources, and range of concerns using a four-point Likert scale. A mean score of 3.0 or above was the selection standard for each item on the judges' rating scale.

Based on the initial review of the questionnaire, the length was reduced and the format altered slightly. Eight

problem areas representing reported mental health needs were presented in the form of eight questions. Each question began with the stimulus statement, "If you or someone close to you were concerned about . . ." The eight topics were family problems, grief, dying, physical changes, using community services, use of leisure time, finances, and suicide. Under each question was the list of the 13 possible response items representing the four categories of acceptability. High acceptability items included: talk to a doctor, clergyman, friend or family member. Moderate acceptability items listed were: to attend a meeting with others, listen to a speaker discuss the problem, watch a T.V. program, read about the topic. Low acceptability items were: to see someone at the senior center, social services center, mental health center, or nutrition project. Do nothing was the last type of response item.

The revised questionnaire was submitted to the panel of judges again. Acceptable mean scores (3.0 or better) were obtained on all items. The judges' ratings and the rating scale are included in Appendix D.

The questionnaire was then submitted to 12 adults over 65 in the community for additional field tests. All questionnaires were completed according to the instructions. Comments regarding the format and the topics of concern were requested as suggested by Henerson, Morris, and Fitz-Gibbon (1978), but none were received.

Data Collection

The survey instrument was distributed to intact groups of older adult participants representative of the target population as defined by the sampling procedures. Sites were selected on the basis of accessibility to the researcher and on the availability of participant groups. These sites included all the nutrition projects in Pontotoc County (Ada, Allen, and Roff), and the major housing projects in the city of Ada (Aldridge Building, Marie Bailey Housing Center, City of Ada Center). All housing projects included an activity center where groups of older adults could be located. At each site, contact was made with the appropriate project director, purpose of the questionnaire was explained, and a time for distribution was established.

Each group was introduced to the researcher, the purpose of the study explained, and volunteers for completing the instrument were requested. Graduate assistants and project staff were available to answer questions and provide assistance as needed. Time was allowed for completion of the survey form before and after scheduled group activities at each site such as the noon meal, birthday party, etc. Efforts were made to reassure the participants of the confidentiality of their responses, and the need for their participation.

The nonaffiliated respondents were contacted primarily through the informal network contacts available to the researcher. Student assistants were instructed in the

purpose of the study, and the instructions for completion of the questionnaire. They were then asked to solicit participation from church members, family members, etc. These nonaffiliated individuals comprised 19% (N=27) of the total sample.

At the time of the group administrations, data was collected on the demographic chartacteristics of the participants present at each site. The distribution of each group on the basis of demographic variables is given in Chapter IV. While Blacks make up 2% of the nutrition project participants, there were only three members of this minority group present on the days selected for administration. None volunteered to complete the instrument. Participants identified as Indian constitute 19% of the total for the nutrition project. Only eight respondents (5.7%) identified themselves as Indian. One site manager identified several of the survey respondents as Indian (based on having a roll number). These respondents did not identify themselves as Indian on the survey form. The manager stated that identification of minority membership was done reluctantly by most participants. This suggests that while the survey seems to underrepresent minority members, it may be typical of the area. On the other variable for which outside data is available (income), the nutrition project participants in Pontotoc County are 70% low income, and the housing projects all require a means test that is evidence of economic need. The total survey included 49 low-income participants (34.6%). Another 48 participants classified themselves as being in the near poverty category.

This results in 69% of the respondents being at or near the poverty level.

Evaluation of the Instrument

Suggested procedures for the evaluation of survey research falls into two broad categories: those sources of error associated with the manner in which the data is collected and those sources of error associated with the instrument itself. The first area is described by Alwin (1978) as including sample coverage, completion rates, and response rates. The latter area includes sources of error due to interviewer variability, question structure and sequence, method of administration, respondent error. Other sources of error examined were acceptability of the survey (Henerson et al., 1978), and effects of misinterpretation (Isaac & Michael, 1977). Each potential source of error was examined separately as listed in the research questions.

Evaluation of Data Collection Method

Sample Coverage. The sample coverage rate was computed on the basis of the number of subjects contacted divided by the estimated number of at-risk adults in Pontotoc County.

Completion Rate. Completion rates for this study were computed by dividing the number of subjects contacted by the number of correctly completed questionnaires received.

Response Rates. The response rate was computed by dividing the total number of individuals present at the

group administrations by the total number of surveys completed correctly and/or partially completed.

Evaluation of PSAS as Survey Instrument

Interviewer Variability. Interviewer variability was examined by sex and race since those charcteristics were identified as being most likely to influence error (Alwin, 1978). The majority of the respondents were female and White as were the researcher, the research assistants and all staff members who assisted with the survey.

Question Structure and Sequence. Question structure was considered in the design of the questionnaire as previously discussed. Question threat, i.e., the appearance of "getting personal" was minimized by avoiding a direct question of need. That is, the questions on the survey form were stated in such a way that the respondent did not have to admit to having a problem in order to answer the question. Also, as recommended by Alwin (1978) a self-administered questionnaire was selected to reduce the threat posed by the the nature of the questions.

Sequencing of questions and sources of assistance items was done by random assignment to avoid systematic influence on the responses.

Effects of question wording such as readability (Myers, 1978), clarity of purpose (Henerson, Morris, & Fitz-Gibbon, 1978), wordiness and ambiquity (Isaac & Michael, 1977) were considered in the construction of the questionnaire. First,

the questionnaire was constructed using the language of similar questionnaires designed for older people such as that of Myers (1978). Secondly, the panel of judges were asked to evaluate the readability and clarity of the instrument.

Method of Administration. Since some of the questionnaires were administered individually, some in small groups, and some in large groups (40 or more individuals present), comparisons of the completion rates and the response rates among the three types of administration conditions were made.

Respondent Error. The panel of judges indicated by the ratings of the PSAS, that the instrument was satisfactory for a majority of the target population. The rating for the readability factor was 3.3 on a four-point Likert scale (four being most acceptable). Clarity also received a mean score of 3.3 from the judges. Appendix D includes the mean scores of the judges' ratings on all factors. The score of three or above as defined on the rating sheet indicated an opinion that less than 10% of the respondents would have difficulty. A pilot study was undertaken to further analyze the ability of the older adult to use the instrument. All questionnaires were returned completed correctly and with no comments. Generally, in survey research, levels of respondent errors are not known (Alwin, 1978). However, since this study sampled intact groups, it was possible to examine the characteristics of those who responded incorrectly

misinterpreted the instructions) and those who responded correctly. This was done by comparing the completed correctly (CC) subsample to the partially completed (PC) subsample and to the subsample who only completed the personal data sheet (IC). The analysis included examination of the three groups on all demographic variables using a Chi-square statistic with a .05 alpha level (Siegel, 1956). Follow-up analyses were performed using Ryan's procedure (Linton & Gallo, 1975).

Misinterpretation. The effects of misinterpretation were examined using the number of respondents who completed the questionnaire (N=110) minus those respondents who completed the PSAS using checkmarks.

Additional analysis of possible respondent error was conducted by comparing the rankings of each of the 13 sources of assistance items for both the CC and PC subsamples. Using the number of times each of the 13 responses items were chosen, each item was ranked from high (1) to low (13). A Spearman's rho was calculated utilizing the paired rankings (Siegel, 1956). An alpha level of .05 was used.

Item Nonresponse. Item nonresponse, as noted by Alwin (1978), presents a special problem. Options suggested include: omit all respondents with missing data, deleting cases on a pairwise basis, or treating the problem in the same manner as coverage and response problems. Since the primary purpose of this study was to develop the survey instrument, item response was defined as the number of

correctly completed questionnaires among those partially completed in whatever form. Specifically, the questionnaires were divided according to those that were correctly completed (CC), those that were completed in a form other than as instructed (PC) such as the use of checkmarks rather than numeric ratings, and those that only completed one section of the questionnaire (IC). For the IC group, those that completed only the personal data were analyzed in the total sample while those that completed only the questions were excluded. No attempt was made to analyze the responses to individual questions since the topics of concern posed in the questions were introduced only as a control variable. The primary analysis was designed to examine only the usefulness of the questionnaire and instructions for general use as a survey instrument.

Missing data on the personal information section were assigned a code (9) and reported in the demographic profile of the sample. Missing data on the questions were given a zero code (i.e., no ranking).

Content Validity. The representativeness of the sample questions included in the instrument (Henerson et al., 1978) was addressed in the development of the questionnaire. The PSAS included major problem areas and resources used by respondents in other surveys. Also, the initial open-ended interviews asked for other topic areas and received no new responses. The pilot study also was designed to encourage reports of additional areas of concern or resources used,

and none were received. Also, during the course of the data collection many comments were received regarding the topics such as "I have a friend who has been worried about this . . . ." One assistant said, "These are the kinds of things my grandparents are always talking about." The instrument appears to have content validity in the area of types of problems faced by older adults and the types of assistance utilized.

Construct Validity. In order to examine the construct validity of the PSAS, the following hypothesis was tested:

> H_1: The young-old, those individuals between the ages of 55 and 74, will have a higher preference for formal services classified as having low acceptability than will the old-old, those individuals 75 and over.

Evidence of differences in preference by these age groups would provide some support for the classification system as suggested by Moen (1978).

In order to clarify the results of these statistical operations, two data transformation operations were performed. First, the order of the rating scale was reversed (1=5, 2=4, 3=3, 4=2, 5=1). This permitted a more logical ordering of the mean scores using the high numerical values rather than the low numerical values for the analyses. The second transformation involved combining the individual ratings of each source of assistance item on each of the eight questions into a total score for that source of assistance. Thus, the score for the item, attend, is the mean sum of the ratings received by the item divided by the total

number of responding individuals. All analyses of data were done with these two transformations.

Using the transformation operations just described, item means were calculated using the SPSS program, Condescriptive (Nie, Hull, Jenkins, Steinbrenner, & Brent, 1975). The second set of operations involved converting the items into the predetermined categories of high acceptability, moderate acceptability, and low acceptability as proposed in Chapter II. The high acceptability scale (H) included the response items: doctor, clergy, friend, and family.

The moderate acceptability scale (M) included the items: attend, listen, watch, and read. The low acceptability scale (L) included the items: senior center, social services center, mental health center, and nutrition project. The last item, Do Nothing, was also included in the comparison of means. For each scale the total sum of the scores of the included items was divided by the total number of respondents to obtain a mean for that scale.

For the purpose of testing the hypothesis, a Friedman two-way analysis of variance was selected (Siegel, 1956). An alpha level of .05 was established. In the event of a significant H, follow-up was done using Nemenyi's test (Linton & Gallo, 1975).

Analysis of Data

The analysis of data involved the computation of the

of the means and standard deviations for the 13 response items as described above. Each item was ranked according to the mean score of that item.

The major research questions regarding the preference of older adults for sources of assistance characterized as highly acceptable over those characterized as moderately acceptable and those over the services classified as having low acceptability were examined in the following manner. The means scores for each item by scale (high, moderate, or low) were ranked. Using a Kruskal-Wallis test with an alpha of .05, the ranks of item by scale were compared. Follow-up analysis in case of significant H was done using Ryan's Procedure for ordered data (Linton & Gallo, 1975).

CHAPTER IV

RESULTS OF THE STUDY

Introduction

Results of the analysis of the data collection method, evaluation of the instrument, and the analyses of the data are presented in this chapter. The chapter describes the evaluation of the data collection method, the examination of the instrument for systematic bias, and the results of the analysis of data.

The distribution of subjects in each category of the demographic variables was examined by type of completion. The Completed Correctly (CC) subsample includes all respondents who completed at least 50% of the questions on both the personal information sheet and the questionnaire itself. This follows the procedures used by Myers (1978). The Partially Complete (PC) subsample includes all respondents who completed the personal data sheet and who used checkmarks rather than numerical rankings on the questionnaire. The Incomplete (IC) subsample includes the information received from respondents who completed only the personal data sheet.

Analysis of Data Collection Method

In order to examine the potential sampling bias, analysis of the returned questionnaires was conducted on the three identified subsamples (CC=85, PC=25, IC=25). Using the methods suggested by Alwin (1978) the results were analyzed for sources of sampling bias and response error.

Sample Coverage

Using 1980 census data and the estimate of needs by Butler and Lewis (1982), the size of the minimum sample was established as 79 of the estimated 798 older adults at-risk in Pontotoc County. As recommended by Feldman (1981), contacts were made with more subjects than actually needed in order to insure a sufficient sample size. A total of 350 older adults were contacted regarding the survey. Of the individuals contacted, 323 were directly affiliated with an aging program or project designed to serve the at-risk elderly. Using the definition of coverage rate given in Chapter I, the coverage rate of this survey was computed as follows: of the 798 individuals estimated to be at-risk, 350 were contacted giving a coverage rate of 43.8%.

Response and Completion Rates

Response and completion rates were computed to examine the sampling bias of the data collection method. The total number and percentage of subjects contacted at each site,

the total number of returned questionnaires, and the number of completed correctly questionnaires are given in Table III. The response rate is the percentage of subjects present at the time of administration who returned a PSAS form. The completion rate is the percentage of correctly completed forms from among those present. The overall response rate was 40%, but the completion rate was 24.3%. The response rate for group administrations was 35%.

TABLE III

RESPONSE RATES BY SITE AND TYPE OF COMPLETION

Site	Number Present	Total Number Respondents	Number of Completed Correctly Instruments	Response Rate %	Correctly Completed Rate %
ADA	180	57	22	32	12
Allen	44	20	11	45	25
Roff	42	11	11	26	26
Aldridge	18	12	9	66	50
Marie B.	20	9	4	45	20
Ada Hous.	19	5	4	26	21
Individual	27	27	24	100	89
Totals	350	141	85	40%	24%

Gay (1976) suggests a return rate of less than 70% is unacceptably low if the results are to be generalized. The purpose of this study was not to generalize results, however, the evidence of lack of participation on the part of the older adult does weaken the use of the questionnaire in the future. Additional evidence of bias is examined in the next section.

Analysis of the Instrument

Method of Administration

The influence of the method of administration was analyzed by comparing the response and completion rates of respondents from the various types of sites. The groups were divided into large group sites where there were 40 or more subjects present; small group sites where there were 20 or less present; and the individual administration which included subjects from nursing homes and the community at large. No group contained between 21 to 39 individuals.

The total number of subjects present, the total number of responses received, and the total number of correct responses received is reported by size of group in Table IV. As can be seen by the data presented in Table IV, the large group sites had a lower response and completion rate than did the small group sites. The individually administered questionnaires resulted in a higher rate of response and completion than did either of the other two groups.

TABLE IV

RESPONSE AND COMPLETION RATES
BY TYPE OF ADMINISTRATION

	Number Present	Total Responses	Response Rate %	Completion Rate %
Large Groups				
Ada	180	57	32	12.2
Allen	44	20	45	25
Roff	42	11	26	26.2
Totals	266	88	33%	16.5%
Small Groups				
Aldridge Bldg.	18	12	66	50
Marie Bailey Bldg.	20	9	45	20
Ada Housing Center	19	5	26	21
Totals	57	26	46%	30%
Individual	27	27	100%	88.9%

Next, the method of administration by type of completion was examined. These results are presented in Table V. The large group, small group, and individual administrations were compared for the number and percentage of correctly completed questionnaires, the number and percentage of partial complete questionnaires, and the number and percentage of incomplete questionnaires. Individual administrations are the

only category of method of administration which shows an acceptable response rate for a survey instrument. This data may be compared with that of Myers (1978) who reported a return rate of 80% from similar sites. Myers (1978) reported the use of research aides in her investigation. However, it appears unlikely that more assistance would improve the return rates from the various sites. Whether this is a result of the survey design or simply a charter-istic of the respondents in this particular study cannot be determined at this time.

TABLE V

NUMBER OF RESPONDENTS AND TYPE OF INSTRUMENT COMPLETION BY TYPE OF ADMINISTRATION

	Number of Respondents	Completed Correctly Number	%	Partially Completed Number	%	Incomplete Number	%
Large Groups							
Ada	57	22	38%	14	24.5%	21	37%
Allen	20	11	55%	3	15%	6	30%
Roff	11	11	100%	0		0	
Small Groups							
Aldridge Bldg.	12	9	75%	2	16.6%	1	1.4%
Marie Bailey Center	4	4	44.4%	3	33.3%	2	22.2%
Ada Housing Center	5	4	80%	1	20%	0	
Individuals	27	24	88.8%	2	7.4%	1	3.7%

In order to meet the minimal cell size as suggested by Linton and Gallo (1975), it was necessary to collapse certain categories within the demographic classifications. These were: Age was combined into young-old (55-74) and old-old (75 and over). Marital Status was collapsed into married and widowed. The not married (N=5) and divorced categories (N=3) were eliminated. Income was combined into low income (under $9,999.00) and over $10,000.00 Education was reduced to zero to 11 years, and high school or above. Living Arrangement was reduced to living alone or living with others. Employment status was combined into working and/or seeking work and not working. The results of these analyses are given in Table VI. Additional analysis on the significant demographic variables were performed using Ryan's Procedure for frequency data (Linton & Gallo, 1975). The use of Ryan's Procedure to allow pairwise comparisons in the Chi-square reduces the liklihood of Type I error by holding the experimentwise error rate constant (Linton & Gallo, 1975). However, the use of a conservative follow-up procedure does increase the probability of Type II error.

The results of the Chi-square analysis, as can be seen in Table VI, are that the variables of income and employment status are related to type of completion. Examination of these classifications using the follow-up procedure described above is shown in Tables VII and VIII.

On the income variable, the only two categories that differ significantly are the completed correctly group and

TABLE VI

CHI-SQUARE ANALYSES FOR CLASSIFICATIONS OF DEMOGRAPHIC VARIABLES

Variable	Number of Responses CC	PC	IC	χ^2
AGE				
55-74	48	14	13	
75+	33	9	10	.09375
SEX				
Male	20	4	8	
Female	61	19	16	1.603
MARITAL STATUS				
Widowed	43	15	15	
Married	31	7	9	.7598
INCOME				
0-$9,999	61	19	17	
$10,000 +	24	0	2	21.40*
EDUCATION				
Less Than High School	39	13	17	
High School Plus	41	10	6	4.595
LIVING ARRANGEMENT				
Alone	42	16	15	
With Other	40	6	8	3.964
EMPLOYMENT				
Working	14	1	0	
NSW	67	19	24	6.316*

*p. < .05

TABLE VII

RYAN'S PROCEDURE RESULTS FOR COMPARISON OF SIGNIFICANT CHI-SQUARE ON INCOME

		PC	IC	CC				
		1.00	.8947	.7176	d	d-1	χ^2	tabled
PC	1.00		.527	8.655*				
IC	.8947			3.63	3	2		5.76
CC	.7176				2	1		4.54

TABLE VIII

RYAN'S PROCEDURE RESULTS FOR COMPARISON OF SIGNIFICANT CHI-SQUARE ON EMPLOYMENT STATUS

		CC	PC	IC				
		.21	.05	0	d	d-1	χ^2	tabled
CC	.21		1.06	3.41				
PC	.05			1.73	3	2		5.76
IC	0				2	1		4.54

the partially correct group with the PC group more likely to have lower levels of income than the CC group. On the follow-up of the employment variable, no pairwise comparison procedured a significant result.

Misinterpretation. Effects of misinterpretation (Isaac & Michael, 1977) was analyzed by computing the percentage of PC respondents from among the total number of respondents who answered both parts of the survey (CC + PC=110). The IC group was excluded from this analysis. It was not clear as to why this group failed to complete both parts of the survey. Reading difficulty, question threat or both could be factors.

The rate of misinterpretation, then, was 22.7% for the entire sample. If the results of the individual administrations are removed, the rate is 30%. Since those individuals who completed the questionnaire individually had an administrator present, there was little opportunity for misinterpretation. Therefore, the rate of 30% is more accurate. In order to analyze sub-group differences and the effects of this misinterpretation, as Hyman (1955) suggested, the scores on the response items by the CC subsample was converted to frequency data and ranked. This ranking was related to the rankings of the PC group using the Spearman's Rho correlation coefficient. The results of this analysis is reported in Table IX. Using the procedure recommended by Siegel (1956) which provides for corrections for ties, a significant level of rho was found ($rho=.927$, $p.<.001$).

TABLE IX

THE ITEMS AS RANKED BY CC AND PC SAMPLES

Item	CC Rank	PC Rank
Scale 1	3	5
Doctor	7	5
Clergy	2	2
Friend	5	7
Family		
Scale 2		
Attend	1	2
Listen	5	2
Watch	10	11
Read	5	5
Scale 3		
Senior Center	9	8
Social Service	8	9
Mental Health	11	10
Nutrition	12	12
Scale 4		
Do Nothing	13	13

The analysis of the instrument indicated that the PSAS was likely to have systematic bias regarding the type of completion and the responses. Evidence suggests that completed correctly questionnaires are related to a higher level of income by respondents and are likely to be related to employment. However, there is a high correlation between the responses of the CC and the PC subsample. Therefore, the effects of misinterpretation do not appear to be as severe as the 30% rate would indicate.

Construct validity. The hypothesis posed to establish construction validity was that the young-old would have a higher preference for formal services described as having low acceptability than would the old-old. The Friedman Two-Way ANOVA (Siegel, 1956) was used to test the null hypothesis. There were no significant differences in the ranked means of the young-old and old-old by the scale conditions of high acceptability, moderate acceptability, or low acceptability ($X^2_r=4$, df=2, p=.167).

The mean scores for the young-old and the old-old by the scales, high, moderate, and low are presented in Table X. It is noted that while the mean scores for the young-old are higher than that of the old-old for services labeled low acceptability, the difference is not statistical significant with a sample of this size.

TABLE X

MEAN SCORES OF THE YOUNG-OLD AND THE OLD-OLD BY SCALES

Group	Scale		
	High	Moderate	Low
Young-Old	49.0	38.8	19.2
Old-Old	48.1	40.3	14.0

Analysis of Data

The initial analysis of the data consisted of computation of the mean and standard deviation of each source of assistance item (items 1-13 on the instrument). The mean, standard deviation, and rank order of each item is shown in Table XI.

In order to examine the research questions, the items were combined into the previously determined scales identified as having high acceptability, moderate acceptability, or low acceptability. The means and standard deviation of each scale in presented in Table XII.

To examine the data for preferences of sources of assistance by level of acceptability, a Kruskal Wallis H test (Siegel, 1957) was used. The results of the Kruskal Wallis test indicated a significant difference (H=43.75, sample sizes=4, p.=.008) among the medians of the scales of

TABLE XI

MEANS, STANDARD DEVIATIONS,
AND RANKS OF ITEMS

Item	$\bar{x}$	SD	Rank
Attend	4.0	2.236	2
Doctor	2.74	1.605	7
Listen	3.294	2.256	6
Clergy	3.365	2.029	5
Watch	1.776	2.043	11
Friend	4.529	2.150	1
Senior Center	1.835	1.717	10
Do Nothing	.365	.986	9
Social Services	2.129	1.71	8
Mental Health	1.071	1.298	12
Nutrition Project	.941	1.499	13
Family	3.835	2.334	3
Read	3.482	2.239	4

TABLE XII

MEAN AND STANDARD DEVIATION FOR SCALES

SCALE	$\bar{x}$	SD	Rank
High Acceptability	48.318	17.452	1
Moderate Acceptability	39.271	19.734	2
Low Acceptability	16.706	11.566	3

acceptability. Using Ryan's procedure for ordered data (Table XIII), significant differences among the medians for high and moderate items and between the medians of the items classified as moderate and low were identified. The difference in the preferred sources of assistance was in the direction predicted.

TABLE XIII

RYAN'S PROCEDURE RESULTS FOR COMPARISON OF SIGNIFICANT H ON SCALE MEANS

		High	Moderate	Low			
		4	5.5	10	d	d-l	z tabled
High	4		-11.49*	-6.79*			
Moderate	5.5			8.49*	3	2	± 2.40
Low	10				2	1	± 2.13

$\alpha = .05$

Summary

The data presented in this chapter raises serious questions regarding the conclusions of this study. There is evidence that the PSAS as a survey instrument introduces systematic bias in the collection process. However, there is some evidence supporting the concept of acceptability as it applies to various forms of assistance available to older adults. The last chapter presents recommendations and conclusions regarding this data.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this study was to develop a survey instrument which could be used to test the hypothesized factor, Acceptability, regarding various methods of mental health service delivery and could, therefore, be used for further research and/or needs assessments in the field. The study involved identifying existing resources, both formal and informal, and identifying those services which were proposed. An instrument was developed to measure the preferences of the older adult for these service methods. Finally, data collected with the instrument was analyzed according to the research question previously stated.

The target population was the 798 older adults in one Oklahoma county estimated to be in need of mental health services. The sampling procedure was designed to contact the aging programs and services in the county where participants were most likely to be members of the at-risk group as characterized by Myers, Murphey, and Riker (1981). Therefore, members of nutrition projects and housing projects where income and/or social need was a prerequisite for participation formed the primary sample. Other residents of

the community at large were contacted including residents of nursing homes, church groups, etc. The 350 individuals contacted regarding the Preferred Source of Assistance Survey (PSAS) represented a coverage rate of 43.8% of the estimated at-risk population.

Next, the PSAS was analyzed for response and sampling procedure error. The overall response rate was 40%. The response rate excluding individual administrations was 35%. These rates do not compare favorably with that obtained by Myers (1978) who reported an overall return rate of 70%, and is described by Alwin (1978) as being low. Warwick and Lininger (1975) suggest a rate of 86% as being very good. Computation of the rate of completion from among those that were sampled produced rates ranging from 12% to 89% at the individual sites. That is to say while 35% of those sampled responded only 24.3% of those sampled responded with a totally correct questionnaire.

Examination of the instrument by type of response revealed that the large group administrations produced the lowest response rates and lowest completion rates. When compared to the response and completion rates reported by Myers (1978), the large group sites had a lower completion rate. Therefore, the large group sites responded less frequently and with fewer correct responses than could be expected based upon other similar surveys of this population.

Analysis of the 85 completed correctly surveys indicated support for the major hypothesis of the study. That is

the service methods classified as highly acceptable received a higher mean score than services ranked as moderately acceptable which ranked higher than those classed as having low acceptability. The option of doing nothing regarding emotional or life task problems received the least support.

Conclusions

As noted in Chapter III, the method of sampling used in this study restricted the target population to the at-risk older adult. Within this constraint, the sampling bias suggests that the PSAS itself introduces systematic bias which favors the more affluent, and working older adult. Therefore, the results may not be valid for the entire community of older adults.

Another source of potential error is the social response bias which could be present. Social pressure to avoid classical helping service agencies would be strong in a group setting.

Based upon the evaluation, the PSAS was found to have systematic bias in that individuals who completed the survey correctly were significantly different than incorrect respondents on the basis of income and employment status. The large group method of administration also produced lower response rates and completion rates. The PSAS as a survey instrument does not appear suitable for general use as a needs assessment instrument with groups of older adults.

The results of the data analyses on the CC sample

resulted in support for the hypothesized factor of acceptability as characterized by the various mental health services included in the PSAS. The results of the data analysis were in the direction predicted for preference of services by type. When the score data of the PSAS itself was converted to frequency data and compared to those who incorrectly responded, there was a significant correlation in preferences. Therefore, a conclusion of this study is that there is evidence that the more informal methods of mental health assistance are more acceptable to the older adult, but these preferences only represent a special segment of the older population in Pontotoc County.

The results of the study suggest there are more acceptable forms of service delivery but does not indicate increased use of these service delivery methods. Since the survey did not ask if the individual would use the service, it cannot be assumed that preferences for recommendations would equal usage if available.

A second note of caution must be voiced regarding the use of volunteers. While it is often assumed that the use of volunteers in a study is a methological weakness, it may also be argued that the volunteer is the most likely type of person to participate or join a self-help group. More precisely, while the volunteer participant may not be representative of those most in need, he or she may be representative of those most likely to use the less formal service modalities. Counselors and other care-givers are

frequently faced with the problems of the reluctant client. Many agencies adopt an underlying premise that the reluctant client cannot be provided for within the existing agency structure. This study did not attempt to address this issue. The purpose of the study was simply to clarify the issues surrounding service utilization for those individuals who would most likely benefit from these services.

There is much evidence to support the belief that the older adult in our society could benefit from mental health services. It is known that this group of individuals utilize these same services at a considerably lower rate than the population as a whole. It has been suggested that cultural conditions over the life span of the older individual has resulted in a reluctance to admit these needs and to formally seek help (Moen, 1978). This study suggests that while there is a reluctance to admit needs personally, there are forms of mental health service delivery which would be more acceptable to the older adult. Therefore, it is suggested that the older, reluctant client may not be reluctant to deal with a mental health need, but he or she may be reluctant to use a particular type of service.

Given the limitations of the study, there is evidence that the factor of Acceptability is an important influence on service preferences of the older adult. Classification of services based upon the characteristics of the service as suggested by Moen (1978) resulted in significant differences in the predicted direction. A test of this classification

of factors was supported in the predicted differences between the scales high acceptability, moderate acceptability, and low acceptability. Analysis of the PC subsample, given the incorrect nature of scores, also supported the hypotheses.

Therefore, it is concluded that the method of service delivery should be considered when designing mental health programs for older adults. The author would suggest that the choice is the provision of less formal services or the continued lack of service utilization by this client group. Given the current rate of utilization of existing services this target population will either go without mental health services or be provided with less formal methods of service. The current trend toward and success of various informal service methods such as peer group counseling and other self-help groups would seem to support this conclusion.

The mean scores for the young-old were not significantly higher than that of the old-old for services labeled as low acceptablitiy. However, the difference in the actual score values was in the direction predicted. The data intuitively appears to support the validity of the construct. The PSAS does not have criterion validity. There is no evidence that indicated preferences would actually result in usage. The study of help-seeking behavior and images of the physician by Nuttbrock and Kosberg (1980) discuss the complexity of this linkage. But, they do suggest that positive image leads to the inclination to seek help.

Given these considerations, the primary conclusion of this study is that additional research, hopefully in the form of a more rigorous survey and/or a demonstration project, is needed. While a true random sample survey using face-to-face interviews would allow tighter controls of the limitations of this study, a demonstration project could be designed to produce criterion validity for the factor acceptability.

Recommendations

There is the obvious need for additional research in the area of service preferences. This research may take several forms: (1) Additional research with the existing instrument as might be done with a true random sample survey using trained interviewers rather than group administration; (2) A revision of the existing instrument might yield a higher response rate; and (3) A demonstration project could be designed to test the actual usage of the suggested service alternatives and develop criterion validity for the service utilization model.

As a result of this investigation, the following questions are suggested for future research in this area.

1. Would a random sample survey yield similar preferences?
2. Can criterion validity for the classification system be developed by a longitudinal study of selected individuals?

3. Would individual administration of the PSAS yield better response rates?
4. What is the reliability of the PSAS?
5. Would a demonstration project offering the various services classified as moderately acceptable improve the utilization of mental health services?

BIBLIOGRAPHY

Abad, V., Ramos, J., & Boyce, E. A model for delivery of mental health services to spanish speaking minorities. American Journal of Orthopsychiatry, 1974, 44(4), 584-595.

Abrahams, R. B., & Patterson, R. D. Psychological distress among the community elderly: Prevalence, characteristics and implications for services. International Journal of Aging and Human Development, 1978-79, 9(1), 1-18.

Adams, J. P. Service arrangements preferred by minority elderly: A cross-cultural survey. Journal of Gerontological Social Work, 1980, 3(2), 39-57.

Administration on Aging. Older Americans Act of 1965, as amended (DHEW Publication No. [OHDS] 79-20170). Washington, D.C.: Author, 1979.

Administration on Aging, Older Americans: Then, now, into the future (DHHS Publication No. [OHDS] 81-20155). Washington, D.C.: Author, 1981.

Alwin, D. F. Making errors in surveys an overview. In D. F. Alwin (Ed.), Survey design and analysis: Current issues. Beverly Hills: Sage Publications, 1978.

Avant, W. R., & Dressel, P. L. Perceiving needs by staff and elderly clients: The impact of training and client contact. The Gerontologist, 1980, 20(1), 71-77.

Barry, J. R. Counseling the aging: A review of 11 current articles. Personnel and Guidance Journal, 1980, 59(2), 122-124.

Benedict, R. C., & Ganikos, M. L. Coming to terms with ageism in rehabilitation. Journal of Rehabilitation, 1981, 47(4), 10-18.

Bengtson, V. L. The institutionalized aged and their social needs. In R. H. Davis (Ed.), Psychosocial needs of the aged: Selected papers. Los Angeles: Ethel Percy Andrews Gerontology Center, 1973.

Bengtson, V. L., & Kuypers, J. A. Generational difference and the developmental stake. Aging and Human Development, 1971, 2, 249-260.

Blake, R. Counseling in gerontology. Personnel and Guidance Journal, 1975, 53(10), 733-737.

Blake, R. Disabled older persons: A demographic analysis. Journal of Rehabilitation, 1981, 47(4), 19-27.

Blazer, D. Life events, mental health functioning and the use of health care services by the elderly. American Journal of Public Health, 1980, 70(11), 1174-1179.

Block, M. R., & Sinnott, J. D. (Eds.). The battered elder syndrome an exploratory study. College Park, Maryland: Center on Aging, University of Maryland, 1979.

Bourestom, N. C. Evaluation of mental health programs for the aged. Aging and Human Development, 1970, 1(3), 187-198.

Brill, N. Working with people: The helping process. Philadelphia: J. B. Lippincott Co., 1978.

Buckley, M. Counseling the aging. Personnel and Guidance Journal, 1972, 50(9), 755-758.

Butler, R. N., & Lewis, M. I. Aging and mental health. Saint Louis, Mo.: C. V. Mosby Company, 1982.

Department of Economic and Community Affairs. Oklahoma population counts by age, race, and sex. Oklahoma City, OK: Author, 1981.

Dunn, D. J. Vocational rehabilitation of the older disabled worker. Journal of Rehabilitation, 1981, 47(4), 76-81.

Eisdorfer, C., & Lawton, M. P. (Eds.). The psychology of adult development and aging. Washington, D.C.: American Psychological Association, 1973.

Elwell, F., & Maltbie-Crannel, A. D. The impact of role loss upon coping resources and life satisfaction of the elderly. Journal of Gerontology, 1981, 36(2), 223-232.

Fandetti, D. V., & Gelfand, D. E. Attitudes towards symptoms and services in the ethnic family and neighborhood. American Journal of Orthopsychiatry, 1978, 48(3), 477-486.

Federal Council on the Aging. The need for long term care information and issues (DHHS Publication No. [OHDS] 81-20704). Washington, D.C.: Author, 1981.

Feldman, E. J. A practical guide to the conduct of field research in the social sciences. Boulder, Colo.: Westview Press, 1981.

Fields, S. Mental health networks: Extending the circuits of community care. Innovations, 1980, 7(1), 2-3.

Fowles, D. G. Some prospects for the future elderly population (National Clearinghouse on Aging Monograph #3, DHEW Publication No. (OHDS) 78-20288). Washington, D.C.: U.S. Government Printing Office, 1978.

Franklin Research Center. Elder abuse (DHHS Publication No. (OHDS) 81-20152). Washington, D.C.: Government Printing Office, 1980.

Friedrichs, K. M. (Ed.) Displaced homemakers. Highlights--An ERIC/CAPS fact sheet. Ann Arbor, Mich.: Counseling and Personnel Services Clearinghouse, 1982 (Winter).

Gaitz, C. M. What we need to know: An approach to research on mental health aspects of aging. Issues in mental and aging, volume I research (DHEW No. ADM-79-663). Washington, D.C.: U.S. Government Printing Office, 1979.

Gaitz, C. M. Barriers to the delivery of psychiatric services to the elderly. The Gerontologist, 1974, 14(3), 210-214.

Ganikos, M. (Ed.). Counseling the aged. Falls Church, Va.: American Personnel and Guidance Association, 1979.

Garfinkel, R. The reluctant therapist 1975. The Gerontologist, 1975, 15(2), 136-137.

Garrett, D. N. The needs of the seriously ill and their families: The Haven concept. Aging, 1978, 289-290, 12/19. (DHEW Publication No. [OHD/AOA] 79-20949.)

Gay, L. R. Educational research: Competencies for analysis and application. Columbus, Ohio: Charles E. Merrill Publishing Company, 1976.

George, L. K. Predicting source of service provider among the elderly. NCBA Quarterly Contact, 1981, 4(4), 4.

Gertz, B., Meider, J., & Pluckhan, M. L. A survey of rural community mental health needs and resources. Hospital and Community Psychiatry, 1975, 26,(12), 816-819.

Golan, N. Wife to widow to woman. Social Work, 1975, 20(5), 369-374.

Gold, B. D. The role of the federal government in the provision of social services to older persons. The Annal of the American Academy of Political and Social Science, 1974, 415, 55-69.

Hanssen, A. M., Meima, N. J., Buckspan, L. M., Henderson, B. E., Helbig, T. L., & Zarit, S. H. Correlates of senior center participation. The Gerontologist, 1978, 18(2), 193-199.

Harris, C. S. Fact book on aging: A profile of America's older population. Washington, D.C.: National Council on the Aging, Inc., 1978.

Henerson, M. E., Morris, L. L., & Fitz-Gibbon, C. T. How to measure attitudes. Beverly Hills, Calif.: Sage Publications, 1978.

Hickey, T. Psychologic rehabilitation for the 'normal' elderly. Mental Hygiene, 1969, 53(3), 369-374.

Husaini, B. A., & Neff, J. A. The mental health needs of southern Oklahoma. Nashville: Tennessee State University, 1979.

Hyman, H. Survey design and analysis. Glencoe, Ill.: The Free Press, 1955.

Isaac, S., & Michael, W. B. Handbook in research and evaluation. San Diego, Calif.: Edits, 1977.

Isaacs, C. D. Evaluation of NIMH aging programs with special focus on services (HEW-NIMH 72-15, PHS HSM 42 72-197). Boston, Mass.: Socio-Technical Systems Associates, Inc., 1974.

Jackson, E. N. Understanding grief. Nashville: Abingdon Press, 1957.

Johnson, R. P., & Riker, H. C. Retirement maturity: A valuable concept for preretirement counselors. Personnel and Guidance Journal, 1981a, 59(5), 291-295.

Johnson, R. P., & Riker, H. C. Counselors' goals and roles to assist older persons. Paper presented at the national convention of the American Personnel and Guidance Association, St. Louis, 1981b.

Kahn, R. L. The mental health system and the future aged. The Gerontologist, 1975, 15(1), Part II, 24-31.

Karls, J. M. Community mental health care of the elderly: A study of policymakers and implementation (Doctoral dissertation, University of Southern California, 1978). Dissertation Abstracts International, 1978, 38(12), 7564A.

Karson, A., & Karson, M. Counseling couples in their sixties. Social Work, 1978, 23(3), 243-244.

Kartman, L. L. The power of music with patients in a nursing home. Activities, Adaptation & Aging, 1980, 1(1), 9-17.

Kelman, H. R. The underdevelopment of evaluation research of health services for the elderly in the United States. International Journal of Health Services, 1980, 10(3), 501-511.

Kerlinger, F. N. Foundations of behavioral research. New York: Holt, Rinehart and Winston, Inc., 1973.

Kethley, A. J., & Herriott, M. Jointly-used elderly client data in mental health and aging programs: Implications for mental health services. Paper presented at the 33rd annual meeting of the Gerontological Society of American, San Diego, Calif. November, 1980.

Khan, N. A. Mental health services to the aged of minority groups. Psychiatric Opinion, 1974, 2(10), 20-23.

Knight, B. Psychotherapy and behavior change with the non-institutionalized aged. International Journal of Aging and Human Development, 1978-79, 9(3), 221-236.

Kubler-Ross, E. Death: The final stage of growth. Englewood Cliffs, New Jersey: Prentice-Hall, 1975.

Kurtz, J. J., & Wolk, S. Continued growth and life satisfaction. The Gerontologist, 1975, 15(2), 129-131.

Larsen, J. K. (Ed.). The greening of old age. Innovations, 1977, 4(1), 1-21.

Lehtinen, V., & Vaisanen, E. Attitudes towards mental illness and utilization of psychiatric treatment. Social Psychiatry, 1978, 13(2), 63-68.

Linsk, N., Howe, M. W., & Pinkston, E. M. Behavioral group work in a home for the aged. Social Work, 1975, 20(6), 454-467.

Linton, P. S., & Gallo, P. S. The practical statistician simplified handbook of statistics. Monterey, Calif.: Brooks/Cole Publishing Co., 1975.

Lombana, J. H. Counseling the elderly: Remediation plus prevention. Personnel and Guidance Journal, 1976, 55(3), 143-144.

Lowenthal, M. F., & Weiss, L. Intimacy and crises in adulthood. The Counseling Psychologist, 1976, 6(1), 10-15.

McCaslin, R., & Calvert, W. R. Social indicators in black and white: Some ethic considerations in delivery of service to the elderly. Journal of Gerontology, 1975, 30(1), 60-66.

McWilliams, S. A., & Morris, L. A. Community attitudes about mental health services. Community Mental Health Journal, 1974, 10(2), 236-242.

Malone, M. Old and on the street. Aging, 1979, 291-292, 20-27.

Markson, E. W., Levitz, G. S., & Gognalons-Caillard, M. The elderly and the community: Reidentifying unmet needs. Journal of Gerontology, 1973, 28(4), 503-509.

Miller, M. Geriatric suicide: The Arizona study. The Gerontologist, 1978, 18(5), 488-495.

Mitchell, C. F. Not another survey: A look at issues in assessing the community needs of the aging. Columbia: Mo.: University of Missouri Social Work Extension Program, 1978.

Moen, E. The reluctance of the elderly to accept help. Social Problems, 1978, 25(3), 293-303.

Moll, L. C., Rueda, R. S., Reza, R., Herra, J., & Vasquez, L. P. Mental health services in East Los Angeles: An urban community case study. In M. R. Miranda (Ed.), Psychotherapy with the Spanish-speaking: Issues in research and service delivery (Monograph No. 3). Los Angeles: University of California, Spanish Speaking Mental Health Research Center, 1976.

Murdock, S. H., & Schwartz, O. F. Family structure and the use of agency services: An examination of patterns among elderly native americans. The Gerontologist, 1978, 18(5), 475-481.

Myers, J. M., & Drayer, C. S. Support systems and mental illness in the elderly. Community Mental Health Journal, 1979, 15(4), 277-286.

Myers, J. E. The development of a scale to assess counseling needs of older persons (Doctoral dissertation, The University of Florida, 1978). Dissertation Abstracts International, 1979, 39(12), 7165-A. Microfilms No. 7907782, 336p).

Myers, J. E., & Loesch, L. C. The counseling needs of older persons. The Humanist Educator, 1981, 20, 21-35.

Myers, J. E., & Murphey, M., & Riker, H. C. Mental health needs of older persons: Identifying at-risk populations. American Mental Health Counselors Association Journal, 1981, 3, 53-61.

National Indian Council on Aging. Mental health and the Indian elderly. NICOA Quarterly, 1(3), 1981, 2-3.

National Institute on Aging. Age page-senility: Myth or madness? U.S. DHHS, Washington, D.C.: U.S. Government Printing Office, 1980a.

National Institute on Aging. Special report on aging 1980 (NIH Publication No. 80-2135). Washington, D.C.: Author, 1980b.

Neuber, K. A. Needs assessment: A model for community planning. Beverly Hills, Calif.: Sage Publications, 1980.

Newhaus, R., & Newhaus, R. Successful aging. New York: John Wiley & Sons, 1982.

Nie, N. H., Hull, C. H., Jenkins, J. G., Steinbrenner, K., & Brent, D. H. Statistical package for the social sciences. New York: McGraw-Hill, 1975.

Norris, E. L., & Larsen, J. K. Critical issues in mental health services deliver: What are the priorities? Hospital and Community Psychiatry, 1976, 27(8), 561-566.

Nuttbrock, L., & Kosberg, J. I. Images of the physician and helping-seeking behavior of the elderly: A multivariate assessment. Journal of Gerontology, 1980, 35 (2), 241-248.

Padilla, A. M., Carlos, M. L., & Keefe, S. E. Mental health service utilization by Mexican Americans. In M. R. Miranda (Ed.), Psychotherapy with the Spanish-speaking: Issues in research and service delivery (Monograph No. 3). Los Angeles, Calif.: University of California, Spanish Speaking Mental Health Research Center, 1976.

Patterson, R. Services for the aged in community mental health centers. American Journal of Psychiatry, 1976, 133(3), 271-273.

Pilsecker, C. Help for the dying. Social Work, 1975, 20(3) 190-194.

Porter, L. Adults have special counseling needs. Adult Leadership, 1970, 18(9), 275-276.

Pratt, C. C., & Kethley, A. J. Anticipated and actual barriers to developing community mental health programs for the elderly. Community Mental Health Journal, 1980, 16(3), 205-216.

Reiter, S., & White, B. Group work with older people utilizing peer counselors. Paper presented at the 26th annual conference of the National Council on Aging, St. Louis, 1978.

Robertson, J. F. Activity preferences of community-residing aged as a guide for practice emphases. Journal of Gerontological Social Work, 1978, 1(2), 95-109.

Robin, E. P. Discontinuities in attitudes and behaviors of older age groups. The Gerontologist, 1971, 2(4), 79-84.

Rosenstein, M. J. Hispanic Americans and mental health services: A comparison of Hispanic, black, and white admissions to selected mental health facilities, 1975 (DHHS Publication No. [ADM] 80-1006. Series CN No. 3). Washington, D.C.: U.S. Government Printing Office, 1980.

Salisbury, H. Counseling the elderly: A neglected area in counselor education. Counselor Education and Supervision, 1975, 14(3), 237-238.

Salmon, H. E. Synopsis of model project for training counseling students and peer seniors in community-based guidance and counseling to serve urban low-income older adults. Paper presented at the national convention of the American Personnel and Guidance Association, St. Louis, 1981.

Santore, A. F., & Diamond, H. The role of a community mental health center in developing services to the aging. The Gerontologist, 1974, 14, 201-206.

Sargent, S. (Ed.). Nontraditional therapy and counseling with the aging. New York: Springer Publishing Co., 1980.

Schmidt, L. D. Issues in counseling older people. Educational Gerontology: An International Quarterly, 1976, 1, 187-192.

Select Committee on Aging, U.S. House of Representatives. National conference on mental health and the elderly. Washington, D.C.: U.S. Government Printing Office, 1979.

Seligman, M. E. P. Helplessness: On depression, development, and death. San Francisco: W. H. Freeman, 1975.

Siegel, S. Nonparametric statistics for the behavioral sciences. New York: McGraw-Hill Book, Co., 1956.

Stensrud, R., & Stensrud, K. Counseling may be hazardous to your health: How we teach people to feel powerless. Personnel and Guidance Journal, 1981, 57(5), 300-304.

Stevens, C. H. Counseling the aged in a public housing project. Personnel and Guidance Journal, 1973, 52(3), 189-193.

Subcommittee on Human Services of the Select Committee on Aging, U.S. House of Representatives. Future directions for aging policy: A human service model (Committee Publication No. 96-226). Washington, D.C.: U.S. Government Printing Office, 1980.

Tolbert, E. L. An introduction to guidance. Boston: Little, Brown and Company, 1978.

Vontress, C. E., & Thomas, H. A. Counseling adults. Adult Leadership, 1968, 17(6), 279-291.

Walders, D. Research consideration for older disabled individuals. Journal of Rehabilitation, 1981, 47(4), 90-93.

Wantz, R. A., Scherman, A., & Hollis, J. W. Trends and implications for training. Personnel and Guidance Journal, 1982, 21(4), 258-268.

Warheit, G. J., Bell, R. A., & Schwab, J. J. Needs assessment approaches: Concept and methods. Washington, D.C.: U.S. Government Printing Office (017-00705-6), 1979.

Warwick, D. P., & Lininger, C. A. The sample survey: Theory and practice. New York: McGraw-Hill Co., 1975.

Waters, E., Fink, S., & White, B. Peer group counseling for older people. Eucational Gerontology, 1976, 1, 157-170.

Weber, R. E. Evaluative reseach: Community mental health services for the aged. Evaluative research on social programs for the elderly (DHEW Publication No. [UHD] 77-20120). Washington, D.C.: U.S. Government Printing Office, 1973.

Wolfe, B. R., & Wolfe, G. Exploring retirement in a small group. Social Work, 1975, 20(6), 481-484.

APPENDIXES

APPENDIX A

COMPREHENSIVE MODEL FOR ASSESSING UTILIZATION FACTORS

I. Predisposing Variable: relates to service need or service utilization

A. Gender

B. Age

C. Race

D. Education

E. Marital Status

II. Enabling Variables: economic and social support variables

A. Economic

1. Household income

2. Health insurance coverage

3. Perception of financial resources

B. Social Support

1. Amount of interaction with friends

2. Amount of interaction with relatives

3. Perception of dependability of friends and relatives

4. Satisfaction with amount and quality of interaction

5. Living arrangement.

III. Need Variables: measures of physical and mental health that are expected to increase the likelihood of service utilization

A. ADL impairments

B. Self-rated health

C. Number of chronic diseases

D. Measure of cognitive and affective mental functioning.

IV. Acceptability Variables: characteristics of service provider which are expected to facilitate service utilization

A. Services which enhance the self-reliance of the individual

B. Services which increase the opportunity for peer contact and mutual assistance

C. Services which enhance the informal network of family and friends

D. Services which require no means test no formal declaration of need.

APPENDIX B

INTERVIEW SCHEDULE

PERSONAL DATA

1. Name _____ 2. SSN _____

3. Address _____
Street City State Zip

4. Data of Birth _____

Circle the letter next to the response most nearly correct for you.

5. Population of Residence:

a. Under 10,000 b. 10-20,000 c. 20-30,000 d. over 30,000

6. Sex: M F

7. Race: a. White b. Negro c. Indian d. Other _____
(specify)

8. Years of Education:

a. 6 yrs or less
b. 7-8 yrs
c. 9-10 yrs
d. 11-12 (high school)
e. 1-3 yrs college
f. College Graduate
g. 1-2 yrs Grad work

9. Income Level Per Year;

a. $4,000 or less
b. $5,000 - $8,000
c. $9,000 - $12,000
d. $13,000 - $16,000
e. Over $16,000

10. Marital Status:

a. Single, never married
b. Divorced
c. Married
d. Widowed

11. Living Arrangements:

a. Living with other than spouse (children, sister, etc)
b. Living with spouse
c. Living alone

12. Work History:

a. Never worked in paid employment.
b. Worked sometimes (less than 10 years).
c. Worked most of adult life (20 years or more).
d. Formally retired (receive company retirement benefits).
e. Currently employed.

COMMUNITY SURVEY

INSTRUCTIONS:

We are conducting a survey to determine the types of community services preferred by the older adult. We are particularly interested in the use of services associated with the common problems faced by people over the age of 55. If you agree to participate in this study, your replies will be confidential. All responses will be added together at the end of the survey. No one individual will have his or her responses identified.

1. During the past year have you, for yourself or for someone you know, sought information or assistance from any community agency or organization?
What was the nature of the request?

What agency or organization did you contact?

2. If you or someone you know had trouble with _____ what would you do?

a. depression

b. grief

c. alcohol or drug abuse

d. lonliness

e. disability

f. not wanting to live

3. If you had a problem of a personal nature that you felt you could not handle, would you seek help?

If so, what type of help would you seek?

4. Name any physical condition, illness, or health problem that is currently bothering you.

5. Is there anything that you are worried about at this time?

6. What community service(s) would you like to have available to you?

APPENDIX C

PREFERRED SOURCE OF ASSISTANCE SURVEY

DEAR SENIOR CITIZEN:

MANY OLDER ADULTS FACE SPECIAL CONCERNS ASSOCIATED WITH GROWING OLDER. PROBLEMS SUCH AS REDUCED INCOME, PHYSICAL DISABILITY OR LOSS OF A LOVED ONE MAY BE HANDLED IN A NUMBER OF DIFFERENT WAYS. THIS SURVEY ATTEMPTS TO IDENTIFY THE TYPES OF ACTION OLDER ADULTS PREFER TO TAKE IF FACED WITH THESE CONCERNS.

YOU ARE ASKED TO HELP NOW BECAUSE YOU ARE OLDER. YOUR ANSWERS TO THIS SURVEY ARE MOST IMPORTANT. THEY WILL BE USED TO PLAN PROGRAMS AND SERVICES FOR OLDER PERSONS. PLEASE HELP BY ANSWERING EVERY QUESTION. ALL ANSWERS WILL BE CONFIDENTIAL.

THANK YOU FOR YOUR HELP.

SSN:___ __ ____

INFORMATION FORM

I am completing this questionnaire voluntarily. I understand that the results will be kept strictly confidential.

INSTRUCTIONS: Circle the number next to the response most correct for you. For example:

My current age is: 1. between 55-64
(2) between 65-69

My current age is:

1. between 55-64
2. between 65-69
3. between 70-74
4. between 75-79
5. over 80

What is your sex?

1. Male
2. Female

What race are you?

1. White
2. Black
3. Indian
4. Other _____ (Specify)

What is your marital status?

1. Never married
2. Divorced
3. Married
4. Widowed

What is your family income?

1. 0 to $3,999
2. $4,000 to $9,999
3. $10,000-$14,999
4. $15,000-$19,999
5. over $20,000

How much school did you complete?

1. 0 to 6 years
2. 7 to 11 years
3. High school graduate
4. Some college
5. College graduate

Do you live with anyone?

1. Living with spouse
2. Living alone
3. Living with someone other than spouse. (Children, relatives, etc.)

What is your employment status?

1. Employed full-time or part-time
2. Seeking work
3. Not seeking work (Retired)

Comments:

Are there any additional concerns or services not on the survey form that you feel are needed?

_____

_____

_____

_____

INSTRUCTIONS FOR ANSWERING SURVEY QUESTIONS

Each question expresses a concern which may or may not be true for you personally. If a statement seems not to apply to you now, pretend that it might at some time be important to you. Answer as if it was important to you now. Remember, the survey does not ask you if you have a problem. It only asks what action would you prefer to take if you or someone you knew did have a concern about the area listed.

Read each question. Under each question is a list of possible actions that you could take. Indicate the five (5) actions you would most prefer to take. Place a one (1) by your first choice, a number two (2) by your second choice, a number three (3) by your third choice, and so forth. For example:

If you or someone close to you were concerned about transportation, you would prefer to:

___Attend a meeting with others who share this	__2__See someone at the Senior Center
__4__Talk to doctor	____Do nothing
___Listen to speaker discuss transportation services	__1__See someone at the Social Services Center
___Talk to clergyman	___See someone at the Mental Health Center
___Watch T.V. program about transportation	__3__See someone at the Nutrition Project
__5__Talk to a friend	___Talk to family member
___Read about transportation services	

1. IF YOU OR SOMEONE CLOSE TO YOU NEEDED HELP IN DEALING WITH CHILDREN OR OTHER FAMILY MEMBERS, YOU WOULD PREFER TO: (SELECT FIVE ACTIONS, 1 = FIRST, 2 = SECOND CHOICE, ETC.)

____Attend a meeting with others who share this concern

____Talk to doctor

____Listen to speaker discuss family relations

____Talk to clergyman

____Watch a T.V. program about family relations

____Talk to a friend

____See someone at the Senior Center

____Do Nothing

____See someone at the Social Services Center

____See someone at the Mental Health Center

____See someone at the Nutrition Project

____Talk to family member

____Read about family relations

2. IF YOU OR SOMEONE CLOSE TO YOU WERE GRIEVING OVER THE DEATH OF A LOVED ONE, YOU WOULD PREFER TO: (SELECT FIVE (5) ACTIONS, 1 = FIRST CHOICE, 2 = SECOND CHOICE, ETC.)

____Attend a meeting with others who share this concern

____Talk to doctor

____Listen to speaker discuss grieving

____Talk to clergyman

____Watch T.V. program about grieving

____Talk to a friend

____See someone at the Senior Center

____Do Nothing

____See someone at the Social Services Center

____See someone at the Mental Health Center

____See someone at the Nutrition Project

____Talk to family member

____Read about grieving

3. IF YOU OR SOMEONE CLOSE TO YOU HAD VERY SERIOUS CONCERNS ABOUT DYING, YOU WOULD PREFER TO: (SELECT FIVE (5) ACTIONS, 1 = FIRST CHOICE, 2 = SECOND CHOICE, ETC.)

____Attend a meeting with others who share this concern

____Talk to doctor

____Listen to speaker discuss dying

____Talk to clergyman

____Watch T.V. program about dying

____Talk to a friend

____See someone at the Senior Center

____Do Nothing

____See someone at the Social Services Center

____See someone at the Mental Health Center

____See someone at the Nutrition Project

____Talk to a family member

____Read about dying

4. IF YOU OR SOMEONE CLOSE TO YOU WERE WORRIED ABOUT THE PHYSICAL CHANGES ASSOCIATED WITH GROWING OLDER, WOULD YOU PREFER TO: (SELECT FIVE (5) ACTIONS, 1 = FIRST CHOICE, 2 = SECOND CHOICE, ETC.)

____Attend a meeting with others who share this concern

____Talk to doctor

____Listen to speaker discuss growing old

____Talk to clergyman

____Watch T.V. program about growing old

____Talk to a friend

____See someone at the Senior Center

____Do Nothing

____See someone at the Social Services Center

____See someone at the Mental Health Center

____See someone at the Nutrition Project

____Talk to a family member

____Read about growing old

(Continued on Back)

5. IF YOU OR SOMEONE CLOSE TO YOU WERE CONCERNED ABOUT OBTAINING SOCIAL SERVICES IN YOUR COMMUNITY YOU WOULD PREFER TO:
(SELECT FIVE (5) ACTIONS, 1 = FIRST CHOICE, 2 = SECOND CHOICE, ETC.)

___Attend a meeting with others who share this concern

___Talk to doctor

___Listen to speaker discuss social services

___Talk to clergyman

___Watch a T.V. program about obtaining social services for community

___Talk to friend

___See someone at Senior Center

___Do Nothing

___See someone at the Social Services Center

___See someone at the Mental Health Center

___See someone at the Nutrition Project

___Talk to family member

___Read about obtaining social services for the community

6. IF YOU OR SOMEONE CLOSE TO YOU WERE CONCERNED ABOUT FINDING MEANINGFUL WAYS TO SPEND YOUR TIME, YOU WOULD PREFER TO:
(SELECT FIVE (5) ACTIONS, 1 = FIRST CHOICE, 2 = SECOND CHOICE, ETC.)

___Attend a meeting with others who share this concern

___Talk to doctor

___Listen to speaker discuss ways to spend time

___Talk to clergyman

___Watch a T.V. program about ways to spend your time

___Talk to friend

___See someone at Senior Center

___Do Nothing

___See someone at the Social Services Center

___See someone at the Mental Health Center

___See someone at the Nutrition Project

___Talk to family member

___Read about ways to spend your time

7. IF YOU OR SOMEONE CLOSE TO YOU WERE CONCERNED ABOUT FINANCES, YOU WOULD PREFER TO:
(SELECT FIVE (5) ACTIONS, 1 = FIRST CHOICE, 2 = SECOND CHOICE, ETC.)

___Attend a meeting with others who share this concern

___Talk to doctor

___Listen to speaker discuss finances

___Talk to clergyman

___Watch a T.V. program about finances

___Talk to friend

___See someone at Senior Center

___Do Nothing

___See someone at the Social Services Center

___See someone at the Mental Health Center

___See someone at the Nutrition Project

___Talk to family member

___Read about finances

8. IF YOU OR SOMEONE CLOSE TO YOU WERE THINKING ABOUT SUICIDE, YOU WOULD PREFER TO:
(SELECT FIVE (5) ACTIONS, 1 = FIRST CHOICE, 2 = SECOND CHOICE, ETC.)

___Attend a meeting with others who share this concern

___Talk to doctor

___Listen to speaker discuss suicide

___Talk to clergyman

___Watch a T.V. program about suicide

___Talk to friend

___See someone at Senior Center

___Do Nothing

___See someone at the Social Services Center

___See someone at the Mental Health Center

___See someone at the Nutriton Project

___Talk to family member

___Read about suicide

APPENDIX D

JUDGES' RATING AND RATING SCALE

JUDGES' RATINGS

Judge No.	Readability	Instructions	Clarity	Resources	Concerns
1	3	3	3	3	3
2	4	4	4	4	4
3	4	4	3	4	3
4	1	2	3	4	1
5	4	4	4	4	4
6	4	3	3	4	4
Total	20	20	20	23	19
x	3.3	3.3	3.3	3.8	3.16

MENTAL HEALTH SERVICE PREFERENCE SURVEY

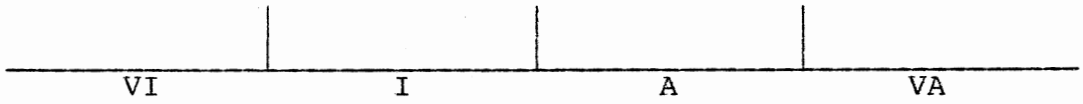
RATING SHEET

INSTRUCTIONS: As someone who has knowledge of the needs and problems of older adults, please complete the attached survey form and rate it on the following items. Place a checkmark above the work that most correctly describes your judgement using the following criteria.

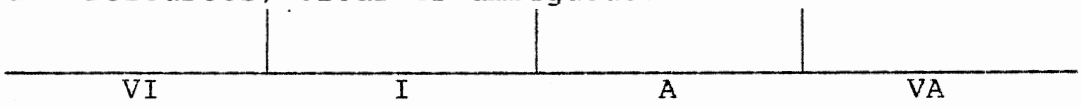
Very Inappropriate (VI)	= 25% or more will have difficulty
Inappropriate (I)	= 10-25% will have difficulty
Appropriate (A)	= 10% or less will have difficulty
Very Appropriate (VA)	= 1% or less of adults over the age of 65 will have difficulty

1. READABILITY: Does the form appear to be at a suitable reading level for the majority of people over the age of 65?

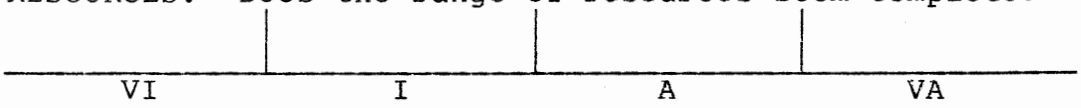
2. INSTRUCTIONS: Are the instructions clear and easy to follow:



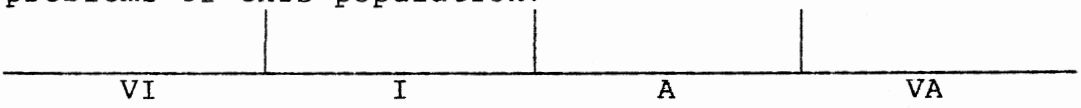
3. CLARITY: Are the items on the survey (topics of concern and resources) clear or ambiguous?



4. RESOURCES: Does the range of resources seem complete?



5. CONCERNS: Do the areas of concern cover the most common problems of this population?



6. COMMENTS/SUGGESTIONS: Please include any comments or suggestions you have for improving this survey. Use the back of the form or attach your comments to this rating sheet.

VITA 2

Barbara Kay Shelton

Candidate for the Degree of

Doctor of Education

Thesis: AN INVESTIGATION OF THE OLDER ADULT'S PREFERRED SOURCES OF ASSISTANCE FOR MENTAL HEALTH SERVICES

Major Field: Student Personnel and Guidance

Biographical:

Personal Data: Born in Gilmer, Texas, December 1943.

Education: Graduated from Altus High School, Altus, Oklahoma, in May, 1962; received Bachelor of Arts in Journalism degree from the University of Oklahoma in May, 1966; received Master of Education degree in Student Personnel and Guidance from the University of Oklahoma in August, 1968; completed requirements for the Doctor of Education degree at Oklahoma State University in December, 1982.

Professional Experience: Employment Counselor, Oklahoma Employment Security Commission, Oklahoma City, Oklahoma, May, 1967 to December 1969; State Counseling Supervisor, Oklahoma Employment Security Commission, Oklahoma City, Oklahoma, January 1970 to February, 1973; Field representative, The National Council on the Aging, Dallas, Texas, March, 1973 to December 1975; Assistant Professor, Department of Human Resources, East Central Oklahoma State University, June 1976 to present.

Professional Organizations: American Personnel and Guidance Association, Southwest Society on Aging, Oklahoma Personnel and Guidance Association.