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IMPROVING THE MENTAL HEALTH CARE DELIVERY SYSTEM FOR ELDERLY NURSING HOME PATIENTS

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ABSTRACT

It is well known that the mental health care delivery system for aged nursing home patients is inadequate. Based on information gained from face to face interviews and from a mail survey of nursing home personnel, the range and usefulness of the resources and services available for mental health care in nursing homes are identified. This information is then used to derive recommendations for the development of a more effective mental health care delivery package for nursing homes.

MENTAL DISORDERS IN NURSING HOMES

Dimensions of the problem.

The diagnosis of mental disorders remains an inexact art with very low reliability (eg., Rosenhan, 1973, 1975; Hoffman, 1982). Consequently, figures on the incidence and prevalence of different types of mental disorders can be treated only as 'best guesses.' Estimates of the

percentage of nursing home residents with mental disorders, therefore, range very widely from study to study, depending primarily on how many of the psychiatric classifications officially recognized by the American Psychiatric Association are counted and on the skills and training of the diagnosticians who make the diagnoses. One national estimate sets the figures at about 58% and 19% respectively for the prevalence of organic brain syndromes and other mental disorders among nursing home patients (1973-74 National Nursing Home Survey, cited in Glasscote, 1976:25). Based at least on these estimates, it would appear that about four out of every five patients in the nation's nursing homes are in need of mental health care services. The dimensions of the need for mental health care delivery in nursing homes are therefore very large. It is well known, however, that the mental health care delivery system in nursing homes is woefully inadequate (eg., Stotsky, 1970; Group for the Advancement of Psychiatry, 1971; U.S. Subcommittee on Aging, 1971; Kahn, 1975; Glasscote et al., 1976,1977; U.S. House Subcommittee on Health and Long Term Care 1976; Berkman, 1977; Gordon and Gordon, 1981; and Butler and Lewis, 1982).

Our concern in this paper is in identifying the range and effectiveness of resources and services that are being used for mental health care delivery in nursing homes. Though some of the resources and services to be described in this report could be used to care for all officially recognized mental disorders, we shall limit our discussions here to their use for only the severe disorders of organic brain syndromes (hereafter abbreviated as OBS) and functional psychoses (hereafter abbreviated as FP). Both of these disorders, particularly OBSs, are

widespread among nursing home patients.

OBS and FP

OBSs are mental disorders attributable to physical impairment of the nervous system as a result of injury, disease, or a number of other factors. The most common diseases associated with OBS among the elderly are Alzheimer's and arteriosclerosis. OBSs resulting from these two diseases are called chronic organic brain syndromes and are not at present curable. Other conditions, however, such as infection, drug abuse, malnutrition, heart disease, stroke, and so on can produce temporary states of OBS known as acute organic brain syndromes.. Since these conditions are sometimes reversible or can often be controlled, a careful physical examination is needed to determine the cause of all observed symptoms of OBS. Only in this way can the reversible conditions of OBS be identified and corrected. Reversible conditions producing temporary symptoms of OBS, however, may also appear after a condition of chronic OBS has been diagnosed, resulting in a compounding of mental disorder symptoms. Continuing follow-up physical examinations are therefore needed even after a chronic OBS diagnosis has been made so as to identify and correct reversible conditions when they occur.

Symptoms of OBS include impairment of memory, intellect, judgment, orientation and emotional control. Psychotic symptoms, such as hallucinations and delusions, may be a part of the OBS or may represent a separate, 'functional' mental problem requiring separate diagnosis and treatment. Because of the inexact nature of the diagnostic process, however, some functionally psychotic residents may be

diagnosed as having an OBS, thus leading to inappropriate treatment (cf., Hoffman, 1982). Worse yet, since no effective treatment for OBS exists, these misdiagnosed patients may receive no treatment at all. This situation is especially likely if the patient is elderly, since deviant behaviors among the elderly, in contrast to other age groups, are commonly attributed to senility.

Symptoms of functional psychoses (FP) are of two major sorts, cognitive and affective, and include hallucinations, delusions, disordered thought, inappropriate affective display, depression, and mania.

Unfortunately, there is no known cure for chronic OBS or for FP. The state of the art of present treatment remains largely maintenance in nature, with emphasis placed on keeping the patient at the highest level of functioning possible and enjoying the highest quality of life as possible. The prognosis is for indefinite long term care

Housing the mentally ill

As a primary health care provider for the OBS and FP patient, nursing homes, as noted above, have been criticized frequently for the amount and quality of mental health care they are able to provide. Insufficient and poorly trained staff, high turnover, low pay, and low morale have all been cited as deficiencies affecting the quality of mental health care nursing homes can deliver. A good deal of the problem, however, stems from the fact that nursing homes were never originally intended to be homes for the mentally ill, but have been pressed into this service by the deinstitutionalization movement.

The passage of Medicare and Medicaid reimbursement funds in the 1960s made it financially possible for an explosive growth to occur in the number of nursing homes nationwide. This growth complimented and was made necessary by the wholesale deinstitutionalization of a very large numbers of mental patients from state facilities. Put simply, the patients had to go somewhere, and if relatives were unwilling to take them into their homes, the patients ended up in nursing homes, boarding homes and homeless on the streets. The result has been that the large state institutions for the mentally ill have been replaced as mental health care providers for many patients by the nursing homes, which are "little community institutions." Glasscote (1976:3), for example, notes that 40% of the elderly released from the state mental health hospitals between 1961 and 1973 were transferred directly to nursing homes. Since the deinstitutionalization movement began, many mentally ill patients who would have gone to the state mental health hospital now are diverted to nursing homes. Again, this is especially true of the elderly mental patient.

Since the housing of mental patients in nursing homes is possible largely as a result of the Medicare and Medicaid programs, it is important to note how the regulations of these programs affect mental health care delivery to those patients. Of the regulations accompanying these new federal funding programs, those of medicaid are the most important at present in their impact on the quality of mental health care in nursing homes. The minimum health care requirements specified and reimbursed through Medicaid for staffing and services in nursing homes have become, with few exceptions, the maximum staffing patterns

and services nursing homes have been able to provide (Glasscote, 1976:82). These regulations do not provide reimbursement for a mental health professional to be on the staff at nursing homes, nor are requirements made that nurses have psychiatric training. Furthermore, most states do not allow communitty mental health centers to bill Medicaid directly for services rendered to nursing homes.

Faced with a very large number of mentally disordered patients and lacking the staff, skills, knowledge and Medicaid reimbursement to provide high quality care to these patients, nursing home personnel have as matters of occupational commitment and of concern for their patients, sought out and made use of a variety of ad hoc mental health resources and services. As noted above, our study was designed to identity and evaluate the effectiveness of these resources and services and to recommend how they could best be put together into a more effective package for improving mental health care delivery to aged nursing home patients.

THE STUDY

Following an extensive literature review, preliminary interviews were conducted with staff members at several nursing homes in an urban area. These interviews were unstructured and centered on the issues involved in the provision of mental health care to nursing home patients. A wealth of qualitative information was obtained at this point in the study about the variety and effectiveness of resources and services being used for mental health care of aged nursing home patients. In order to get more standardized estimates of the usefulness of these diverse resources and

services, a structured questionnaire was developed from this initial information and was filled out by the staff in eight of twenty-five nursing homes in the same urban county. The nursing homes represented by this sample ranged in size from 60 to 272 beds and included both intermediate and skilled care services. All but one of these homes was proprietary.

The quantitative estimates that were obtained from the questionnaire conformed fully to the qualitative observations that were made in the earlier interviews, lending convergent validity to our findings. These findings were further validated by being presented at a local workshop for nursing home and community mental health center personnel. Discussions with the workshop participants provided additional evidence of the accuracy of our basic findings concerning the range and usefulness of the various resources and services for mental health care in nursing homes. Dialogue with these workshop participants also confirmed the viability and importance of our recommendations for improving the organization of mental health care delivery to nursing home residents.

Estimates obtained from our questionnaire indicate that of all the residents in the nursing homes in our sample, 55% and &% respectively had a diagnosis of OBS or FP. That is, two-thirds of the patients have a severe mental disorder. These estimates no doubt underrepresent the true prevalence of severe mental disorders among the patient population. It is clear, nonetheless, that there is an extensive need for the delivery of mental health services to patients in the nursing homes in our sample.

The major mental health resources and services that were being used for these patients are listed in Table 1 by order of the frequency of their reported use. The resources included attending physicians; family and friends of patients; community mental health center; city, county or state agencies; volunteers (other than family); local hospitals; ministers; and nursing school traineeship programs. The services included reality orientation, psychotropic drug therapy, remotivation therapy, group psychotherapy, individual psychotherapy, behavior modification, electroshock therapy, and milieu therapy. The frequency with which each resource was used ranged from all eight nursing homes (100%) using attending physicians to no homes (0%) using local nursing school traineeship programs. The estimated percentage of all residents receiving each service ranged from 52% for reality orientation to none for electroshock. These estimates were provided by the directors of nursing at the various facilities. Also obtained from directors of nursing were ratings of the usefulness of each resource and service for mental health care. We shall provide a summary discussion of the effectiveness of each resource and service in turn and then draw out implications for how mental health care delivery in nursing homes can be improved.

MENTAL HEALTH RESOURCES

Attending Physicians

The most used resource for mental health care in nursing homes are attending physicians. It is ironic that family physicians or physicians who are assigned to patients are the principal mental health resource for nursing homes, since these

physicians generally have very little training in mental health care (see Goldberg, Latif and Abrams, 1970:221; and Hoffman, 1982). It is no doubt for this reason that they are rated by directors of nursing as being only slightly useful in providing mental health care and are used almost exclusively to obtain prescriptions for psychotropic drugs.

Widespread discontent was voiced over the difficulty in getting physicians to come out to see patients. As one director of nursing put it: "Unless I can line up six or seven patients to be seen by a doctor, they generally don't want to come out; they don't feel there is enough money in it to make it worth their while." Of course this criticism is more true for Medicaid reimbursed doctors than for family physicians, but it must be kept in mind that the majority of nursing home residents are on Medicaid.

Physicians were also faulted for failure to seek professional, psychiatric consultation and for failure to provide follow-up evaluation of patients when psychotropic drugs were prescribed (cf., Glasscote, et al., 1976:70-71). Frequently drugs were prescribed over the phone to be used by nursed prn. Several nurses expressed frustration with this since they lacked the training to make judgements about when it is most appropriate to administer the drugs, how log to continue them, what their side effects are, how they interact with other drugs, and what a maintenance dosage given current blood level amounts should be. Blood level tests were rarely done in any case, resulting in what nurses believed were probable over- and under - use of drugs. Follow-up evaluation by physicians of the results from using these drugs were infrequent.

Family and Friends

The second most frequently used mental health resource is family and friends of the patient. As a resource, however they were not found to be particularly useful. While family and friends could provide a good deal of emotional support to patients by serving as central reminders of the identities they had established in their lives, this support often is not forthcoming.

Nursing home personnel can give examples readily of how family and friends of patients have a big help not only in providing hands-on physical care for a patient, but in helping them to deal with stress, grief, and depression. As one nurse pointed out: "Each patient needs lots of love, and no one can provide the same sort of love to an elderly patient than a son or daughter or grandson or niece can give." By the same token, however, no one can inflict the same sort of emotional pain that a son or daughter or grandson or niece can by failing to visit, or by unkind words or actions. Family fights are a common part of social life, and they carry over into the nursing home setting. Feelings of guilt, rejection, frustration, resentment, and power struggles for family dominance can result in open disputes, cruel remarks, and even physical aggression.

Unfortunately, the staff of the nursing home all too often are left to deal with the unpleasant outcomes of these struggles between patients and relatives. They are faced, for example, with frequent, unfair criticisms from guilt-ridden family members concerning the care provided to their loved ones and with denial of the very real mental and physical problems the loved ones

possess. And they are left in every case to soothe patients distressed over the infrequency of visits by relatives or to pick up the pieces after family fights occur. A domineering daughter of a patient, for example, visited her mother every day, keeping her in a constant state of agitation and upsetting well-meaning staff members as well. Far more common as a problem, however, are the infrequent visitors, who show no appreciation of the hard work put in by the staff to keep mother or dad clean, alert, and as healthy as possible, but who complain loudly about real or imagined deficiencies in service.

Community Mental Health Centers

Community mental health centers (hereafter abbreviated as CMHCs) and other city, county, and state agencies are the next most commonly used mental health resources, being used by 5 of 8 (62%) of the nursing homes in our sample. Of all resources, CMHCs received the highest rating for their usefulness for this purpose, while other city, county and state agencies were not rated as particularly useful. We shall discuss the CMHC first and then consider the other agencies used by nursing homes.

One would expect the local CMHC to be the most important mental health resource for nursing homes, and consequently it is surprising at first to find that three of the nursing homes had no relationship with their local CMHC. But even of the five who maintain some level of relationship, in almost all cases the relationship is minimal. The reasons that such relations tend to be minimal or non-existent are too complex to detail here, but at least some cursory observations are needed.

The community mental health movement resulted in the creation of community mental health centers that were intended to provide services to all persons within prescribed catchment areas. In fact, inadequate funding has meant that catchment areas and CMHCs have been created at present for only about a fourth of the U.S. population (Butler and LEwis, 1982:275). Therefore, not all nursing homes have local CMHCs as a possible resource, though those in our sample did. Furthermore, nursing homes generally have found CMHCs to be uninterested in the aged, in OBS, and to be ideologically opposed to nursing home care. Indeed, it was recognition of the continuing failure of the CMHCs to meet the needs of the elderly that resulted in the legal requirement by the Public Health Service Act of 1975 (Public Law 94-63) that federally funded CMHCs make a special effort to reach the aged. As a result of this law, CMHCs began to set aside staff time for geriatric services. But even as of the recent federal deregulation of the CMHCs under President Reagan, many CMHCs still had not met these stipulations by developing aging teams or engaging in much in the way of outreach to the aged. And even those with active aging teams paid little attention to the nursing home resident, in contrast to other aged persons in the community, despite the fact that the aged in nursing homes were easy to find and were very much in need of services.

CMHCs were established under the new mental health ideology of keeping people out of large institutions for long term care and in productive lives in their communities. Nursing homes, as themselves institutions for long term care, violate this cherished tenent. It is not surprising, therefore, that CMHC workers in the four catchment areas of the county of

our study verified in interviews we conducted with them that they considered nursing homes to provide inappropriate environments for the treatment of mental patients. We found among CMHC workers widespread lack of interest in working with nursing homes. But even more important that this ideological opposition to nursing homes is, we believe, the lack of interest by CMHC workers in the elderly as patients and in OBS as a mental disorder. Both the elderly and the OBS patient, and certainly the elderly OBS patient, are largely written off as being bad investments of time, energy and scarce resources and as being unpleasant clients with which to work. Furthermore, we were told again and again that current funding emphases are on the 'young chronic.' The term 'chronic' we found cryptically to exclude OBS; 'youth' ended somewhere in the fifties and definitely by the sixties.

In short, CMHCs have not actively solicited nursing home referrals and have been generally lackadaisical and even uncooperative in providing services to them when asked. The services they offer are generally restricted to patient evaluation and to consultation on psychotropic drug prescriptions when asked. Extensive inservice training for nursing homes had been offered by a CMHC in one of the four catchment areas of our study up until the time that the state cut all funding for consultation and education. Emergency calls were discouraged, and in only one nursing home in the entire county was CMHC staff time provided for regular, ongoing therapy in the form of individual and group counseling (this service was a special project funded by the city and state). Follow-up care and evaluation was otherwise limited or non-existent.

Several directors of nursing told us of the enormous frustration they feel when a patient experiences a severe psychotic episode, or deteriorates to an unmanageable condition, and yet they are unable to get either the local CMHC or the attending physician to come out to do something about it. If CMHC workers do come out, it is usually one, two, or more days later, and they then request large amounts of documentation of the history of the episode. Of course they need as much information as possible to make their best judgement about what to do, but their demands are frequently unrealistic in view of the pressures on time faced by nurses. As one nurse put it, their demands for information: "would require us to be authors, keeping elaborate notes of everything patients do and say, everything their families do and say, and everything we do and say." Furthermore, CMHC workers frequently accuse the staff of exaggerating the problem or, even worse, creating it. Several directors of nursing told us that CMHC workers made them feel that it is they who are "crazy," not the patients. Naturally this does little to facilitate good will by nurses toward the CMHC, nor is it anything but a blow to nursing home staff morale.

As a consequence, CMHCs are rarely called by the nursing home personnel, despite the overwhelming number of mental disorders they must deal with among their patients. They have also learned to call CMHCs for only certain requests, such as drug consultation. Even this is done rarely, however, since it is a billed procedure that requires the initiation and authorization of he attending physician, who, as noted above, is usually not present or adequately oriented to psychiatric care.

Within the context of these very restricted relations with the local CMHC, directors of nursing find what services they receive from the CMHC to be very useful. But in almost all cases we were told that more services were much needed and would be much appreciated. The exceptions were the directors of nursing who had simply run out of patience with the CMHC; as one put it: "We have no relationship with the CMHC and wish to continue the present relationship."

City, County and State Agencies

Under the general heading of city, county, and state agencies, only the State Department of Social Services was mentioned as being in moderately frequent use as a mental health resource, though is was not considered to be particularly helpful for this purpose. The assistance it provides is, for the most part, informational. Direct assistance was occasionally given in dealing with patients who were a danger to themselves or others, in making alternative placement evaluation, in obtaining volunteers and financial assistance, and in providing social worker visits to aid in patient adjustment to the nursing home or in family counseling. Shifting public financial priorities, however, kept these services limited and their continuation uncertain.

Clergy

Ministers, other volunteers, and the local hospitals were used as resources for mental health care by half (50%) of the nursing homes in the sample. Ministers and other volunteers were both found to be somewhat useful for this purpose, tying for second place behind only the CMHC as the most useful of resources. Hospitals, on

the other hand, were found to be only slightly useful.

Clergy can shake some patients out of lethargy and withdrawal, giving them a renewed sense of purpose and hope. They can also alleviate pent-up feelings of guilt, grief, emptiness, and betrayal, feelings that are common among nursing home residents. They furthermore can assist in putting patients back into contact with the dominant beliefs of our culture. They frequently fail to achieve these ends for a variety of reasons, however. And this is why only half of the nursing homes made any use of clergy for this purpose.

Modernday clergy, particularly in Protestent and Jewish sects, are trained more in the intellectual aspects of their faiths, than in aspects which are emotional or people-oriented. Consequently their messages of solace, love, and hope far too often are conveyed via high-sounding pronouncements of distant principles and abstract concepts, rather than through warn physical contact or through honest, immediate expressions of pleasure in being in the presence of a fellow believer. One nurse told us that she found Catholic priests to be better than clergy of other faiths at reaching patients and raising their spirits because they seem more adapted to close, earthy interactions with their parishioners. Prostetent clergy, by contrast, often seem aloof and distant, failing to remember names of patients or to give patients a warm embrace. Some nursed found they couldn't even get a local minister to come to the nursing home; as one director of nursing put it: "They are impossible, and I don't know what to do about it." Another said: "They give us the impression of "Who cares'."

Volunteers

Surprisingly, half (50%) of our sample did not use volunteers (other than family or friends) for mental health purposes, though the half who did found them more useful than any resource other than CMHCs. Volunteers can help with activities and with group and individual counselling. They also have the time to provide the extra love and attention to patients that families may not provide and that nursing home staff can give only so much of in view of the limits of their time and emotional energy. Recruiting, organizing and supervising volunteers, however, requires a good deal of time, and nursing homes are often too understaffed to carry on an active volunteer program. The activities and social services directors have their hands full and have neither the time nor usually the training to put together and run such a program. Volunteers are usually adequately available from church, fraternal and educational organizations, but without the capacity to plan and supervise their services, they can provide services that are inappropriate or ineffective for residents, and may end up standing around not knowing what to do, or simply getting in the way of ongoing required nursing activities.

Local Hospitals

The local hospitals were a source of great frustration for many directors of nursing. Only half had any relations at all with local hospitals, and further questioning revealed that these relations consisted almost entirely of emergency hospitalization for acute psychotic breakdowns of residents; other sorts of mental health services from hospitals were very rarely forthcoming. Though four (50%)

of the nursing homes in our sample had found it necessary to seek emergency hospitalization for patient mental disturbances during the past year, only three had formal arrangements with a local hospital to handle such psychotic emergencies. As one director of nursing put it: "I have tried to get a patient admitted to the local hospital, but without success, even for crisis intervention." As another put it: "They refuse to admit or help." And yet another: "It is literally impossible to get any kind of admission for acute psychotic or alcoholic behavior without court orders, actual assault, 72 hour hold, or other procedures requiring too much time to be useful in a crisis situation." Such comments were commonplace in our interviews and questionnaires results.

Nursing School Traineeship Programs

A final resource we asked about, but which had received little usage, was the local nursing school traineeship programs. Though none of the nursing homes in our sample had made use of this resource, we did find a nursing home during our preliminary interviews that had. This nursing home had a traineeship program for local psychiatric nursing students who came into the home twice weekly to provide therapeutic counseling and group sessions for residents with OBS and FP. The nursing personnel at this home found this to be a very useful adjunct to their own services and were quite enthused about it. The did note, however, that it requires a good deal of planning, supervision, time, and effort from their staff to be useful. Also, the usefulness of the students depended a lot on the personal characteristics of each individual student and on the level of supportive instruction given by the local

school faculty.

MENTAL HEALTH SERVICES

The services we identified in our study are listed in Table 1. Here we will discuss the extent of usage and the effectiveness of eac

Reality Orientation

The most frequently used mental health service in nursing homes is reality orientation, with aproximatatly 52% of residents in the nursing homes in our sample receiving it. As the name suggests, the service is intended to bring patients into contact with those basic elements of reality that make social life possible, such as their identity, their geographic location, the date and time of day, the objects in their environment, current public events and past personal histories (see Drummond, et al., 1978). Along with remotivation therapy, group psychotherapy, and behavior modification, this service ranks among the most satisfying of those offered in nursing homes. An additional question asking directors of nursing to rank all services in order of their usefulness resulted in reality orientation being selected first by 50% of our sample.

Two particular advantages of reality orientation are that it requires little training to administer and it can be given continuously as nurses go about performing their usual physical care activities. In fact, all nursing homes reported using it, and some indicated that they used it for all patients. Typical comments are as follows: "Aids and staff are trained to talk to residents and not around or through them"; "It is important to involve the

resident in everything you do and to let him feel that this is his home"; "All staff members participate by action and words"; "we have a tape for one patient who keeps asking about important events in her life; the highlights and important events are on the tape for her to play." In all of our face-to-face interviews, we found enthusiasm for reality orientation.

There are some problems with reality orientation, however, as there are with all mental health services for severely and chronically mentally ill patients (see Schwenk, 1979). As noted earlier, the state of the art in mental health services for such patients is largely maintenance in nature and sets as its primary goal that of improving the quality of the patients immediate life; no dramatic recoveries are to be expected. It is consequently very easy to experience occupational 'burn-out' as one applies the services over and over and over again with little or no sign of patient improvement. Indeed, this is the most common complaint to be heard about reality orientation. As one nurse put it: "How many times can you tell someone what their name is or that you are not 'out to get them' without getting very tired of doing so, getting bored, Feeling very, very hopeless or going 'crazy' yourself." Many nurses noted the excitement they felt when a patient suddenly would speak for the first time in month during reality orientation, would suddenly recognize an apple, or suddenly remember his former occupation. This excitement would eventually turn to frustration however, since the patients inevitably and quickly return to their stupor or delusions. Were such short returns to reality really worth the endless hours of effort? This is a question everyone asks of themselves. Our observations suggest that those nurses who

stay in their jobs longest tend to be those who report that the effort is worthwhile and satisfying.

Psychotropic Drug Therapy

After reality orientation, the next most commonly used mental health service is psychotropic drug therapy. A little more than one fourth of all patients in the nursing homes of our sample were reported to be receiving psychotropic drugs. Of all mental health services, however, psychotropic drug therapy was rated least satisfying by directors of nursing. Many of the problems here can be traced to the earlier discussion of the lack of adequate psychiatric training by attending physicians, the failure to seek out professional psychiatric evaluations and recommendations on drug prescriptions, and the general inadequacy of follow-up evaluation of drug performance. One director of nursing expressed her belief that the prescription of long term, maintenance, psychotropic drug therapy for many of her patients was frequently done as a matter of convenience by attending physicians who simply did not want to take the time with patients to try any other kind of therapy. It was very common, for example, for prescriptions to be given over the phone with no personal examination being made. It is not surprising under these conditions that psychotropic drugs have produced so little satisfaction as a therapeutic technique.

Though highly touted in the popular press, scientific conclusions concerning the usefulness of psychotropic drugs must remain cautious. Contrary to widespread belief, the extensive release of patients from the state mental health hospitals did not occur because of the introduction of

psychotropic drugs. The extensive release of these patients, which began during the early to mid-sixties, was more the result of the community mental health movement, the introduction of the Great Society poverty programs (particularly Medicare and Medicaid), and the rise of the nursing home industry, than it was of the introduction of psychotropic drug therapy a full decade earlier.

Drug therapy for chronic OBSs remains largely underdeveloped and ineffective, while drug therapies for FPs continue to be at best experimental. Though there are popular hypotheses, no conclusive evidence exists for how psychotropic drugs, such as the phenothiazines, work on the central nervous system; and of course there are no sure ways to predict what the results of the use of these drugs will be for any given patient. To be effective, careful follow-up evaluations are therefore required when these drugs are administered.

But in addition to these problems, all researchers freely admit that these drugs do not cure persons of mental disorders, but merely assist in controlling the presentation of some of the more undesirable symptoms. Drug therapy, therefore, remains a maintenance therapy, with continuing remission of all symptoms after the cessation of drugs being credited, it it occurs, either to some other sort of therapy or to an unknown spontaneous dynamic. Unless used with careful evaluation before, during and after application, drug therapy can prove to be ineffective, to produce highly undesirable short term or long term (and even permanent) side effects, and even to produce conditions that mimic symptoms of mental disorders. In the latter case, the patient may be misdiagnosed as being

afflicted by yet another mental disorder and be given more psychotropic drugs to counterbalance these effects (see Hoffman, 1982).

In short, psychotropic drugs are in wide usage in nursing homes as a therapeutic service for the mentally disordered. They are not, however, producing satisfactory results according to nursing home personnel. The problem lies in the lack of skilled use of these drugs and in the lack of adequate follow-up evaluation. The dimensions of the problem nationwide are probably much greater than would be implied by the estimate in our sample of 26% psychotropic drug usage by nursing home patients. Glasscote (1976:74) found in his national sample that 56% of skilled nursing home patients received antipsychotic drugs and 12% received anti-depressants. A 1974 Senate report (U.S. Senate Subcommittee on Aging, 1974) indicated that on average patients in the nations' nursing homes receive 4.2 different medications of all sorts per day. The widespread use of psychotropic drugs coupled with their potential for interactions with the many other drugs being used, poses a quite serious issue in long term care of the elderly patient.

Remotivation Therapy

The only other mental health service in wide use was remotivation therapy, which was applied to 23% of the nursing home patients in our sample. No other service received ratings as high as this one among nursing homes that used it.

The motivation of patients is a common part of nursing home care, especially for patients who have become bedridden, incontinent, who have lost other self-care

skills, who no longer care about their personal appearence, or who refuse to eat or to leave their beds. Getting patients to engage in activities that stimulate their muscles and their minds or that could provide enjoyable, rewarding experiences if physical or emotional doubts could be removed are also common problems. In many cases nurses practice what is often called 'cookie therapy', that is, food is offered as an incentive to get a patient to bath, to brush their hair, or so on. Sometimes stern directives help, and in other cases warm encouragement seems best. In general, the skills are the same as any parent uses to get their adolescent children to make their beds, quit lying around on the couch, eat healthful foods, help around the house, get better grades at school, etc. This it true because in many respects the lives of nursing home patients are as transitional and disconnected from viable social roles as are the lives of most adolescents.

Like reality orientation, remotivation therapy is a set of common-sense practices that are part and parcel of everyday social life. Anyone can apply remotivation techniques with little or no training. As is true of reality orientation, however, 'burn-out' of staff using these techniques on recalcitrant patients is high. Because desired results tend to occur more frequently and to last for longer periods of time, however, satisfaction with remotivation therapy tends to be greater than for reality orientation. It must be kept in mind, however, that these two kinds of therapies apply to different sorts of patients: A certain lever of reality orientation is required in order for remotivation to be successful. Following remotivation, or concurrent with it, more advanced services, such as occupational and recreational therapy, are needed.

Psychotherapy

Only three to four percent of nursing home residents in our sample are receiving any form of psychotherapy, either in groups or as individuals. Psychotherapy was reported to produce somewhat satisfying results, however, by staff who use it. Most psychotherapy that is occurring is done in groups and is led by minimally trained or untrained volunteers.

Psychotherapy is a 'talk-therapy' that encourages people to discuss openly their problems, their hopes and their fears and to reach some sort of healthy resolution about their future goals and past actions. Talk therapy seems to work best for the well-oriented, motivated individual who suffers from repressed feelings of guilt, grief, abandonment, rejection, inferiority, and so on. Such feelings are of course common among nursing home residents. Talk therapies, however, have not found to e particularly effective in alleviating major symptoms of organic brain syndromes or functional psychoses. Furthermore, evidence, although sketchy, suggests that talk therapies are effective when applied by minimally trained therapists as by therapists with advanced training (see the review on this issue in Orford, 1976:169-170). Given the likely magnitude of repressed feelings among the residents in nursing homes, it is therefore not surprising that we should find even such limited use of psychotherapy by minimally trained individuals to result in relatively high levels of satisfaction by directors of nursing.

Behavior Modification

Less than one percent of nursing home residents are receiving behavior modification treatment, though this service is rated by directors of nursing as second only to remotivation therapy in terms of its satisfactory effects. 'Cookie therapy,' as described above is a form of behavior modification, though it can not be expected to have an enduring effect unless it is carefully scheduled and secondary reinforcers are eventually introduced.

Behavior modification in nursing homes generally has not advanced beyond 'cookie' or 'cigarette therapy' because skilled therapists are needed to make continual evaluation of the behavior or patients and of the stimuli of the nursing home environment. Furthermore, all staff would have to work together to create and maintain the sort of environment that would be needed to shape patient behavior successfully. Unfortunately, nursing homes have neither the staff nor time to make such an effort possible. Another problem, of course, are the possible infringements on patients' rights that behavior modification may impose.

But yet another, more fundamental problem is the fact that the natural stimuli of the environment of the nursing home can themselves have perverse effects on patient behaviors (e.g., Lieberman, 1968). Designed to deliver maintenance and rehabilitative services to patients, the peculiar characteristics of the nursing home can nonetheless, and quite unwittingly, produce the opposite effects of deterioration and even death among patients. As is true in any institution for residential living, living conditions are highly regimented and public, with

people expected to eat, sleep, and to control and restrict their behaviors in accordance with bureaucratic rules designed to facilitate the ease with which the institution itself can be operated. Behaviors are monitored twenty-four hours a day, day after day, and corrective action is taken for rule infraction. The contrast between the lifestyle and freedom of action experienced by the patient before entering the nursing home and the regimentation of the nursing home itself poses an exceedingly difficult adjustment problem for new patients and can lead to the rapid deterioration of their physical and mental conditions and to earlier than expected deaths.

Once in the nursing home, previously favored activities may be restricted or forbidden, and contacts with friends, former neighbors or relatives become more distant, irregular and uncontrolable. In response to the loss of these natural avenues of self-expression and activity, patients become agitated or excessively subdued. Symptoms of withdrawal and depression, as well as inactivity, become common. The institutional response to these problems is to introduce artificial activities to try to fill up the patients' time and to keep them as physically and mentally active as possible.

Unlike persons in other institutions for residential living, such as the army, monasteries, or communes, patients in nursing homes not only face a lifestyle not of their own making ad disjointed from the one of their past, but they face this environment with very real and generally severe physical and mental illnesses. What's more, most face it with the awareness that their previous personal identities are dead or dying and that they

now await only physical death itself. To be most effective, the application of behavior modification must take into ccount and control for all of these detrimental impacts of institutional stimuli on patient motivation and behavior.

A major advantage of behavior modification is that, like drug therapy, it does not require the understanding or cooperation of the patient in order for it to work, which makes it ideal for the deeply confused organic brain syndrome patients or the delusional, functionally psychotic patients. Unlike drug therapy, however, it requires an enormous amount of staff time to administer. Furthermore, there is insufficient evidence to believe that behavior modification can produce enduring changes in nursing home patient behaviors after therapy is ended. As long as a patient is in a well-controlled environment, or a 'token economy,' behaviors can be shaped to a remarkable degree. When the therapy is ended by the removal of these rigid environmental controls, however, patients can revert to their former undesirable behaviors unless careful introduction of secondary reinforcers has been made and these secondary reinforcers are present in the patient's uncontrolled environment. Given the environmental stimuli of the total institution, as described above, reversion to undesirable behaviors seems all the more likely if behavior modification therapy is ended.

On the positive side, given the relatively high satisfaction shown with behavior modification by those few nursing home personnel who have tried it in a least a simplified way, more extensive application of it in the remotivation of patients would certainly seem advisable. Trained personnel on staff in the nursing

homes would be required to make this possible.

Electroshock Therapy

The remaining services included in this study were provided either to no residents or to very,very few. Electroshock, for example, was given to no patients, despite the fact that it is known to be effective in alleviating symptoms of psychotic depression.

Nurses were quite open in telling of their dislike of the very idea of electroshock. Yet it is ironic that prejudice against the use of electroshock as a treatment far exceeds that toward the use of psychotropic drugs, since there are few grounds for such a bias in choices. Little more is known, for example, about how psychotropic drugs work to produce desirable effects than is known about how electroshock works to produce desirable effects. Furthermore, in contrast to drug treatment, electroshock treatment for chronic depression is of very limited duration, produces rapid results, and more often leads to complete remission of symptoms. Finally, the undesirable side effects of electroshock, viz., confusion and loss of memory, are certainly no worse than those found from some psychotropic drug therapies, such as hypotension, jaundice, leukopenia, heart problems, respiratory failure, Parkinsonism, tardive dyskinesia, agranulocytosis and retinitis. Yet a fourth of all nursing home patients in our sample are placed on long term, maintenance regimens of psychotropic drug therapy, with little or no follow-up evaluation, while none receive electroshock treatment.

Milieu Therapy

We included milieu therapy in our questionnare even though earlier interviews led us to believe that we would not find anyone using it. Our interest in this service stemmed from the literature which suggested that milieu therapy could be among the most useful forms of treatment (e.g., Colthart, 1974). Since nursing home personnel were unacquainted with the term, we added a definition of it to the questionares.

In milieu therapy, as in behavior modification, all staff, including aids, come together to discuss problem patients and to decide how best to coordinate their actions to deal with each patient most effectively. By involving everyone in these meetings, higher rapport and morale is created, as well as more consistent and coordinated treatment of the patient by all staff. It is especially important to have aids involved because they provide virtually all hands-on care to the patients.

Nursing homes are all presently using a very limited variation of this model when the director of nursing seeks information from select staff members to decide how to deal with a problem patient. Routine patient care conferences were also common, where relevant staff would meet to consider the medical circumstances, problems, and rehabilitative potentials of each patient.

Other Services

The only other services mentioned were sensory stimulation, recreational therapy, and family conferences. These services were reported as being in use for mental health purposes for less than one percent of the residents however. Sensory

stimulation is an adjunct to reality orientation in which patients are presented objects to touch, smell, hear, and so on and are oriented simultaneously to the meaning of the object. Music therapy, for example, is a form of sensory stimulation. Dance therapy, which involves sensory stimulation, is a form of recreational therapy that often is used after patients have become remotivated to engage in activities (music therapy, of course, could also be use as a recreation therapy).

Family conferences are held on an ad hoc basis, provided families were willing to get involved. Generally these conferences are problem-solving meetings designed to discuss how to deal with problems posed by the patients' behavior or with problems the patients or relatives are having with the health care practices of the nursing home. Quite often the meetings deal with such issues as how to get a patient to stop aggressive behavior or to take prescribed drugs. Directors of nursing related, however, that: "We find that we spend a good deal of time and effort in these conferences 'treating' the family." Since so few nursing homes report using patient care conferences for mental health purposes, it would seem that it has been found to be more trouble than assistance (which is not to neglect the real importance of providing 'treatment' for the family).

Recommendations

The problem of how to make public provision for society's chronically mentally ill persons will likely remain a serious issue for the foreseeable future.

Unless some rather remarkable breakthroughs occur in the technology of mental health therapy, continuous care and treatment of these persons in residential-based facilities will likely remain the way in which this public obligation will have to be met. With the deinstitutionalization of mental patients from costly state mental health hospitals, we saw the rapid growth of the nursing home industry to provide residential services. While deinstitutionalization alleviated the states from the full financial burden of health care costs for the mentally ill, it merely shifted a major share of these costs onto the federal programs of social security, Medicare, and Medicaid. As a result, for example, nursing homes now collect a little more than half of all the money spent by the federal government on Medicaid each year.

While deinstitutionalization resulted in a governmental shift of the financial burden for the provision of public mental health care services to the aged mentally ill, it would appear that it has otherwise merely taken the mental patient out of the frying pan of the big mental health institutions and put them into the fire of the little mental health institutions of nursing homes, where mental health care delivery is woefully inadequate. Such a conclusion is overly hasty, however. Nursing homes have been found by some researchers to be less dehumanizing than the state hospitals and generally more healthy places for the elderly mentally ill to be (e.g., Glasscote, 1976, Stotsky, 1973); furthermore, nursing homes do not necessarily differ much from the state institutions in the actual amount of mental health services offered, since the state institutions were themselves woefully inadequate in this regard. Still, the range and quality of mental health services

that are being offered in the nation's nursing homes are unarguably far less than a humanistically-oriented society would desire. Based on our study, therefore, we would like to draw up recommendations for how mental health resource utilization and service implementation can be improved in nursing homes.

First, since Medicaid is the principal public funding source for services to the aged in nursing homes, its policies must be changed to recognize and deal with the pervasive existence of severe mental disorders among nursing home patients. A careful, professional evaluation of the mental as well as the physical health of all nursing home residents is needed at patient intake and periodically thereafter, and should be reimbursable by Medicaid. These evaluations should be conducted by skilled, psychiatrically trained professionals. Treatment plans should then be drawn up to include an outline of therapies and goals not only for physical rehabilitation and maintenance, but for mental rehabilitation and maintenance as well.

Second, Medicaid reimbursement should be extended to provide funding for a full-time mental health worker in the nursing home, such as a clinical psychologist, psychiatric nurse, or psychiatric social worker. Despite the preponderant numbers of mentally ill in nursing homes, present Medicaid regulations make no such provisions. The resident mental health worker would provide services to be described shortly.

In addition to Medicaid changes in the funding of nursing home operations, community mental health centers (CMHCs) need to be better funded so as to be able

to provide outreach therapy, consultation, and education to nursing homes. Furthermore, CMHC staff should be better trained to provide these services to the elderly and to nursing homes. Contracts reimbursable through Medicaid and state departments of mental health should be made between CMHCs and the nursing homes in their catchment areas so as to make closer, continuous service delivery possible. When nursing homes are not in the catchment area of a CMHC, similar services should be contracted through local hospitals or mental health clinics. Given the concentration of severely mentally disabled residents in nursing homes, CMHCs (or other contracted mental health providers) should devote at least a full-time staff position simply to provide services to nursing homes in their catchment areas.

Attending physicians are rarely competent to deal with a specialty problem, such as mental illness, and, for a variety of reasons, are generally unwilling to devote face-to-face time with nursing home patients. They are therefore unlikely to become a useful resource for mental health care of the elderly and probably contribute a great deal to the misuse of psychotropic drug therapy. With regular psychiatric evaluation of patients being conducted as described above and with a consulting CMHC worker and a full-time mental health worker on the nursing home staff, the attending physician will be relieved of the responsibility of recognizing mental health needs when they occur. Furthermore, all prescriptions for psychotropic drugs should be cleared through the consulting psychiatrist, and professional follow-up evaluations of the effectiveness of the drugs should be written into the treatment plan. The effective use of psychotropic drug therapy, and electroshock as well, can

no doubt be much improved if applied under professional, psychiatric direction.

Reality orientation, remotivation techniques and individual and group psychotherapy are services generally found to be useful in nursing homes, though they have not all received widespread use. Reality orientation and remotivation techniques can be readily learned by nursing home staff and applied as a part of their ongoing patient care services. Because of high staff turnover, however, continuous in-service training would need to be provided by either the resident mental health worker or by the local CMHC worker. Individual and group psychotherapy should be used more extensively and could be conducted by the following persons: The resident mental health worker, the CMHC worker assigned to the nursing home, and by volunteers working under the guidance of the mental health worker.

The importance of the effective use of volunteers cannot be overemphasized. Found to be among the most useful of resources for mental health services by directors of nursing, volunteers remain nonetheless a much underutilized resource in many nursing homes. Reality orientation, remotivation therapy, and individual and group psychotherapy can be extremely time-consuming, trying services that easily lead to staff 'burn-out'. This is especially true when these services are used for the continuing maintenance of the quality of life of severely mentally ill patients, that is, those with organic brain syndromes and functional psychoses. Volunteers, however, provide an ever fresh supply of

energy for the delivery of these services and may be able to do so with minimal training and supervision.

We would propose that the recruitment of such volunteers from civic organizations, church groups, and schools (especially local social worker, clinical psychology and psychiatric nursing programs) be made a primary responsibility of the social services director. Training and supervision of these volunteers should be the shared responsibility of the resident mental health worker and activity director. Finding, training and supervising these volunteers will require staff time and commitment, but could easily lead to a payoff of ten or more free hours of service for every staff hour devoted.

Our data suggest that this balance of resources and services would provide the most practical and effective package for improving the mental health care delivery system for aged nursing home residents. While some of our recommendations require new funding of staff positions and service contracts, others require simply a reallocation of existing resources. The proposed new funding is reasonable in view of the very large, unmet, mental health care needs in nursing homes. Furthermore, it is a public obligation for us to provide maintenance and rehabilitative care for these severely mentally ill nursing home patients. These individuals have otherwise become excluded from residential services in state mental health hospitals by the deinstitutionalization movement and consequently have been forced into nursing homes as the only available alternative for residential mental health care. Coupled with the proposal for reallocation and reemphasis of staff duties and service mix, the specific refunding proposals we have

made would lead to a substantial increase in the quality of mental health care in the nation's nursing homes.

REFERENCES

Berkman, B.
1977 "Community Mental Health Services for the Elderly." Community Mental Health Review, 2, 2-9.

Butler, R. N. & Lewis, M. I.
1982 Aging and Mental Health: Positive Psychosocial and Biomedical Approaches. C.V. Mosby Company, ST. Louis, Mo.

Colthart, S.
1974 "A Mental Health Unit in a Skilled Nursing Facility." Journal of the American Geriatrics Society, 22, 453-456.

Drummond, L., Kirchhoff, L. & Scarbrough, D. R.
1978 "A Practical Guide to Reality Orientation: A Treatment Approach for Confusion and Disorientation." The Gerontologist, 18, 568-573.

Glasscote, M., Gudeman, J. E., & Miles, D. G.
1976 Old Folks at Homes: A Field Study of Nursing and Board-and-Care Homes.American Psychiatric Association, Washington, D.C.

Glasscote, M. and others.
1977 Creative Mental Health Services for the Elderly. American

Psychiatric Association, Washington, D.C.

Goldberg, H. L., Latif, J., & Abrams, S.
1970 "Psychiatric Consultation: A Strategic Service to Nursing Home Staffs." The Gerontologist, 10, 221-224.

Gordon, R. E. & Gordon, K. K.
1981 Systems of Treatment for the Mentally Ill: Filling the Gaps. Grune and Stratton, New York.

Group for the Advancement of Psychiatry
1971 The Aged and Community Mental Health: A Guide to Program Development. Group for the Advancement of Psychiatry, 8 (report 81), New York.

Hoffman, R. S.
1982 "Diagnostic Errors in the Evaluation of Behavioral Disorders." Journal of the American Medical Association, 248, 964-967.

Kahn, R. L.
1975 "The Mental Health System and the Future Aged." The Gerontologist, 15 (1, part II), 24-31.

Lieberman, M. A.
1968 "Institutionalization of the Aged: Effects on Behavior." Journal of Gerontology, 23, 343-353.

Orford, J.
1976 The Social Psychology of Mental Disorder. Penguin Books, New York.

Rosenhan, D. L.
1973 "On Being Sane in Insane Places." Science, 179, 250-258.

1975 "The contextual Nature of Psychiatric Diagnoses." Journal of Abnormal Psychology, 84, 462-474.

Schwenk, M. A.
1979 "Reality Orientation for the Institutionalized Aged: Does it Help?" The Gerontologist, 19, 373-377.

Stotsky, B.
1970 The Nursing Home and the Aged Psychiatric Patient. Appleton-Century-Crofts, New York.

1973 "Extended Care and Institutional Care: Current Trends, Methods, and Experience." pp 167-177 in B. W. Busse and B. Pfeiffer (Eds.), Mental Health in Later Life. American Psychiatric Association, Washington, D.C.

House Subcommittee on Health and Long-Term Care of the Select Committee on Aging, House of Representatives, 94th Congress.
1976 New Perspectives on Health Care for Older Americans. U.S. Government Printing Office, Washington, D.C.

U.S. Senate Special Committee on Aging, Subcommittee on Long Term Care.
1971 Mental Health Care and the Elderly: Shortcomings in Public Policy. Washington, D.C.

1974 Nursing Home Care in the United States: Failure in Public Policy. U.S. Government Printing Office, Washington, D.C.

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TABLE ONE: Director of nursing evaluations of each mental health resource and service being used in nursing homes, ranked by frequency of their use.

RESOURCES			SERVICES		
	% of nursing homes using this resource (n=8)	average usefulness score on a five point scale		average % of patients receiving this service	average satisfaction on a five point scale**
1. attending physicians	100	3.7	1. reality orientation	52	4.1
2. family and friends of patient	88	3.2	2. psychotropic drug therapy	26	2.8
3. community mental health center	62	4.5	3. remotivation therapy	23	4.7
4. city, county or state agency	62	3.2	4. group psychotherapy	3	4.0
5. volunteers (non-family)	50	4.0	5. individual psychotherapy	1	3.5
6. local hospitals	50	3.4	6. behavior modification	1	4.4
7. ministers	50	3.9	7. milieu therapy	0	#
8. nursing school traineeship program	0	#	8. electroshock therapy	0	#

* 1 = not at all useful; 2 = not very useful; 3 = neutral or uncertain; 4 = somewhat useful; 5 = very useful

** 1 = very dissatisfied; 2 = somewhat dissatisfied; 3 = neutral or uncertain; 4 = somewhat satisfied; 5 = very satisfied

not calculable