IS THERE A HOME FOR DEPENDENT CHRONICALLY MENTALLY ILL ELDERS
IN THE TWENTY FIRST CENTURY?
A REVIEW OF THE LITERATURE AND CLINICAL PRACTICE

By

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To the Faculty of Washington State University:

The members of the Committee appointed to examine the clinical research project of CARLA LOUISE NOVAK find it satisfactory and recommend that it be accepted.

Chair

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Abstract

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The purpose of this paper is to focus on what constitutes a successful residential option for the chronically mentally ill elderly (CMIE). Alternative residential facilities for the dependent CMIE who do not suffer from primary dementia were examined. This was done by a review of the literature and clinical practice. Community based programs that offer support to the CMIE who are at high risk of residential placement but live independently, are explored. Several types of alternative residential options to institutionalized care, and the importance of nursing care for the CMIE, are described. The importance of a comprehensive mental health assessment of the CMIE at the time of referral to the program or facility, and the value of ongoing consultation by a nurse specialist are discussed as two highly significant factors to successful mental health treatment in community based programs and alternative residential facilities.
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Dedication

In memory of my father, William J. Witzel,
who demonstrated the potency of willpower and who
was a source of great inspiration to me.
Introduction

Mental illness is a group of disorders that continues to be misunderstood. People with mental illness have been stigmatized for centuries. Society takes different views of the mentally ill depending on current resources, the visibility of the population, moral trends of the time, and knowledge of mental illness. (Talley & Coleman, 1992)

From the beginning of the 1900s until the early 1960s the mentally ill, including the elderly, were institutionalized in asylums or specialized state facilities. The Community Mental Health Act passed by Congress in 1963 mandated the deinstitutionalization of the mentally ill from these facilities. The transition of the mentally ill to the communities often happened without adequate resources and discharge planning to community based programs. (Stroul, 1989) During this time the Medicaid program encouraged states to shift reimbursement for residential care from state hospital facilities to nursing homes. During the 1970s, the population of chronically mentally ill elderly (CMIE) in state hospitals declined by 40% with a subsequent increase in the nursing home population. (Committee on Nursing Home Regulation, 1986)

The 1987 Omnibus Budget Reconciliation Act (OBRA-87) included the Nursing Home Reform Act (NHRA) of 1987. This act requires all nursing home applicants to meet medical/physical criteria for nursing home admission. As part of the OBRA regulations, all patients admitted to nursing homes must be pre-screened for possible mental health problems and are required to have an evaluation for appropriate placement and treatment. This process is called the Pre-Admission Screening and Annual Resident Review (PASARR). (OBRA, 1987)

Research has indicated dissatisfaction with the PASARR process. Findings of inadequate, disorganized evaluations were common. In studies reviewing the PASARR process, screening was found to have little correlation of demographic and clinical profiles with treatment recommendations. Also noted was a lack of provision for alternate placements if the residents
were not found to physically qualify for nursing home placement. (Borson, Loebel, Kitchell, Domoto, & Hyde 1997; Sherrell, Anderson & Buckwalter, 1998)

In a study conducted by Marek, Rantz, Fagin, and Wessel-Kerjci (1996) that examined the general effects of OBRA in nursing homes, the authors explored the perspectives of a broad group of nursing home employees, regulators, advocates, professional associations and nursing home residents. Several questions were asked about mandated OBRA assessment, which included the Minimum Data Set (MDS), Resident Assessment Protocols (RAPs), and the PASARR. Of the three assessment tools required, both the MDS and RAPs received support. Participants were generally not supportive of the PASARR. Forty-nine percent of the participants thought it should be changed and 58% noted problems with it. Along with concerns noted the previous studies, two other common themes emerged. The first was the need to eliminate the medical diagnosis as the key indicator for admission as this often screened out people with primary diagnosis of mental illness and secondary medical problems. Several long-time residents were uprooted from nursing homes for this reason. The second pointed to a lack of resources for residents identified as needing mental health treatment. The authors made recommendations that the PASARR, because it should be re-examined, had not worked as a screening tool. (Marek et.al., 1996).

In a literature review that examined data on the effects of OBRA-87, including preadmission screening, the findings reported by Snowden and Byrne (1998) found that the PASARR screening and review program was highly criticized. The authors noted that the industry awaits the publication of data to guide the PASARR regulations and help guide the next round of implementation and reform.

OBRA-87 requires nursing homes to provide basic mental health services for its residents and to give active mental health treatment and services to residents who are admitted with a
serious mental illness. (OBRA, 1987) Nowhere in the OBRA legislation, however, are there
requirements that mandate nursing homes to take CMIE that have been identified in the
PASARR evaluations. The OBRA legislation does not offer solutions or residential alternatives
to nursing home placement, nor does it make recommendations as to how to provide mandated
mental health treatment with current dollars.

Why are Alternative Residences Needed for the CMIE?

Lack of mental health resources

Despite the need for mental health services for residents in nursing homes, the services
provided are drastically below what is required for adequate treatment. In their study looking at
the potential cost of providing mental health services to CMIE in nursing homes, Shea, Smyer,
and Streit, (1993), used data from the Institutional Population Component (IPC) and the National
Medical Expenditure Survey (NMES) for numbers of CMIE in nursing homes. The authors
obtained data, such as what type of mental health services were available, and key information
about the need for services, from facility data. The facility data were collected from nursing
directors or administrators. Resident data were collected with the assistance of a facility staff
member who was selected on the basis of his/her knowledge of the sample resident or knowledge
of the resident chart. The residents’ medical records were examined for a listing of any of the
major psychiatric disorders. Previous use of mental health services was measured by a question
in the resident survey, which determined whether the resident had received any treatment by a
psychiatrist, psychologist or other mental health worker during their time in the facility. Cost was
determined based on two sources; the median fee for individual service in a hospital and the fee
determined from the Medicare Resource Based Relative Value Scale (RBVS).

The numbers of residents with a primary diagnosis of mental illness, excluding Alzheimer
Disease (AD) or other related dementias (ORD,) were greater than 25%. Almost one-quarter of
the mentally ill population that reside in nursing homes report not receiving mental health services. Eighteen percent of the CMIE rely on independent providers to come into the nursing home and provide services. The data showed that less than three-fifths of the mentally ill population had some formal arrangement through contracts or staff to provide mental health care.

The cost estimate, which excluded treatment for AD and ORD, and estimated 12 annual service charges for each client indicated a range from a minimum of 480 million to more than 1.3 billion dollars. This creates a staggering economic impact on nursing homes to even provide minimal mental health treatment. Limitations to these findings are that the estimation of cost could be higher or lower due to the paucity of data on the current state of mental health services in nursing homes, the type billing codes used for mental health services, and the lack of clarity in the OBRA 87 mandate. The authors were quick to point out that nursing homes often ‘refer out’ residents who have primary mental health diagnoses to other facilities or simply do not admit them at the time screening, as it is not in the OBRA mandate to take them. (Shea et. al., 1993)

A study done by Burns, Wagner, Taube, Magaziner, Permutt, and Landerman (1993) demonstrates that cost savings in for-profit facilities may affect the amount and quality of mental health care that the CMIE receive. Their study looked at treatment of mental illness for the CMIE in nursing homes prior to the enactment of OBRA-87. They found that a very small percentage of residents received mental health care at all. If the resident were Medicaid funded, they were less likely to be referred for specialty care, suggesting that a poor rate of reimbursement affected the specialty care that residents got.

Other studies have indicated a lack of adequate mental health treatment in nursing homes. (Borson et. al, 1997; Timko, Nguyen, Williford, & Moos, 1993; Talley & Coleman, 1992) The need for mental health treatment for the CMIE who live in public housing is also evident. A study by Black, Rabins, German, McGuire, and Roca (1997) examined epidemiologic survey
data from elderly residents of six public housing developments in the Baltimore area to
determine the prevalence of need and unmet needs for mental health care. Andersen’s Behavioral
Model was used to provide the structure for identifying factors associated with mental health
service use among residents who needed it.

The six sites were selected for the two-stage survey because they received no focused
psychiatric intervention. Trained interviewers provided brief screening interviews to residents in
stage one. The three reliable screening instruments used were the General Health Questionnaire
(GHQ), the Mini-mental State Examination (MMSE), and the Cage Questionnaire (CAGE) for
determining addiction problems. Stage two included a diagnostic assessment for all participants
who screened positive on the instruments and a 10% random sample of negative screens. The
assessments were made within 30 days of Stage 1 interviews. A total of 945 residents were
screened at Stage I, and 298 participated in the Stage II assessment interview for an overall
response rate of 83%. Eighty-four percent of the subjects were female and 95% were African
American. Data were weighted to adjust for sampling and Stage II data. Descriptive and bivariate
statistics were used to summarize the sample characteristics and estimate the prevalence of need
for mental health care and the use of mental health services. Factors associated with needing
mental health care were determined using multiple logistic regression analysis. (Black et. al.,
1997)

Thirty-seven percent of the sample needed mental health services and 58% of those who
needed care had unmet needs. Those at greater risk of both needing mental health care and
receiving no mental health care services were males, residents who were older, those with no
Medicare insurance, and those with more activity of daily living (ADL) impairments. The
authors stated that the prevalence of need for mental health care (37%) was more than four times
higher than reported by Shapiro et al. in their 1985 study, which was 8% for elderly living in the
community at large (as cited in Black et al., 1997). This finding suggests an increase in the need for mental health services in the CMIE one decade later. The authors point out the need for mental health services may be even greater than is suggested by the prevalence rates they found because the elderly commonly underreport psychiatric symptoms and residents who meet strict diagnostic criteria may represent only a lower limit of need. (Black et. al., 1997) The results of the study underscore the unmet needs of the CMIE in public housing.

Unique needs of the CMIE

CMIE have unique needs that are not necessarily provided in nursing homes or public housing. In a study that examined the quality of care in three types of facilities in which the CMIE resided, Timko et. al. (1993) sought to determine how quality of care was related to patient functioning. They also explored how patients’ dependency on others for self-care moderated relationships between quality of care and patient functioning. The authors used discriminant function and multiple regression analyses to examine twelve-month follow-up data from a Department of Veterans Affairs study of 294 chronically mentally ill adults in three different residential facilities. The three facilities were differentiated by staff and resident characteristics as well as by facility policy.

The CMIE’s adaptive functioning was positively related to a better quality of physical environment with a flexibility of daily routine and services that promote the development of skills. If residents were completely dependent on others for self-care, the availability of orientational aids and prosthetic aids were helpful and associated with more vigor, but for residents who were rated as not needing help on any activity more prosthetic aids were associated with less vigor. Orientational aides were associated with less anxiety and depression when used on highly dependent residents, but with residents who had little or no dependency, more aids were associated with more anxiety and depression. Policy development in residential
facilities impacted the CMIE residents, in that the less restrictive the policies, the more independent the residents became. Functional status of the residents was an important factor in determining where the residents should live. An environment with more functionally able peers, and policies that provided residents with more control, appeared to benefit the CMIE. Depending on the level of impairment, facility characteristics such as structural aids, opportunities for control, services, and staffing needs had a differential influence on residents’ adaptation. (Timko et. al., 1993)

A study in Washington State examined 63 discharges from a state psychiatric facility to nursing homes. Interviews with residents, observational ratings of the facilities, and a survey of residential care providers were used to look at how integration of the resident happened externally in the community and internally within the facility. Rigidity of routine and social distance of care staff were noted as important factors that kept the CMIE from functioning at optimal levels in residential nursing homes. (Kruzich, 1986)

In a dated study examining the CMIE that were relocated from a mental hospital to a nursing home, Marlowe (1976) found that relocation resulted in deterioration for a majority of the elderly. But residents who went to places where autonomy was encouraged, and who received personalized treatment with encouragement to integrate into the larger community, functioned better than those who went to environments who rated opposite on these dimensions.

The CMIE who experience symptoms of their mental disorders often do not seek help and thus are less likely to receive intervention. The CMIE often do not seek out care or accept services that are offered because they do not recognize or acknowledge that they have a mental health problem, however severe psychological distress will prompt the CMIE person to access mental health services. (Black et. al., 1998) As a result, the symptoms may be exacerbated to a point that more intensive intervention is necessary.
In a descriptive survey research project that looked at differences between services provided to chronically mentally ill residents under the age of 60, and those who are 60 and over, Richter, (1989) found that services for the CMIE differed from those provided to younger CMI residents. The project targeted 173 facilities certified to accept psychiatric patients in Colorado. Of those facilities, completed questionnaires were received from 58 nursing homes, which accounted for 33% of the total psychiatric population of 1,185 psychiatric residents identified by the Colorado Department of Health. Twenty-seven facilities responded that they were unable to participate in the study for a number of reasons.

Nursing home staff rated employment or vocational counseling, activity therapy, and reminiscence therapy as the most effective services for the CMIE when utilized daily or a minimum of twice weekly. Social rehabilitation and psychotropic medications were similar in frequency of use and effectiveness. In the age group 60 and under, all activities were utilized more frequently with the exception of mental health support groups. Medications, reality orientation, and activity therapy were rated as most effective (Richter, 1989).

In a literature review that studied research of programs designed for the CMIE, J. Richter (1990) noted that the research is limited. Reality orientation and therapeutic milieu are the interventions that have most often been applied successfully with this population, and that interacting with the CMIE and providing emotional support is most therapeutic of all.

As described above, the CMIE have unique mental health needs that often are not provided for in nursing homes or the community. The next section will review research on alternative residential options.

Residential Options for the CMIE

As psychiatric hospitals continue to reduce their numbers of long-term beds for the chronically mentally ill, which includes the CMIE, options for their permanent residence need to
be available. Each year the geriatric population continues to increase. The growing elderly population impacts long-term care (LTC) facilities, such as nursing homes. As noted in the above section, the CMIE population has unique needs and does not always get the proper treatment it requires in nursing homes or the community. In the last decade there have been numerous programs and residential units proposed and piloted that provide residential arrangements for the CMIE. In this section, several community support and alternative residential options are described.

Community Support Programs

Clearly residential alternatives are needed for the CMIE as the elderly population continues to increase in the next decade. Another viable area that may be an option for the CMIE is community supports that allow them to live in their own homes as long as possible. Several programs are highlighted in this sub-section that offer innovative ways to offer community based services to the CMIE. Training and financial resources, along with community collaboration are necessary to support these programs in their success.

The Gatekeeper Program. In Spokane, WA, this program was begun in 1978 through the cooperative efforts of Spokane Community Mental Health Center and the Eastern WA Area Agency on Aging (Knight, Rickards, Rabins, Buckwalter, & Smith, 1995, chap. 2). It has received national attention and numerous awards for its innovative efforts in linking the community to provide mental health, health care, nutrition and other supports to the CMIE. The program is comprised of two components. The Telephone Information and Assistance (I&A) component provides short-term assistance for those who have other support systems in place. It provides in-home assistance, which can include an assessment and evaluation, treatment for mental or physical needs, and assistance in obtaining the needed supports. If necessary the client is referred to the second component, a clinical case-management team. This team, which
represents the Multi-Disciplinary In-Home Case Management component, focuses on the most at risk CMIE. Its mandate is to prevent premature or unnecessary institutionalization by helping maintain the CMIE in their homes. Eighteen case managers, six team leaders, a full-time psychiatrist, consulting family medicine practitioners, and a program coordinator, staff five multidisciplinary teams.

The most publicized feature of the Gatekeeper Program is its system of case-finding that inspired its name. The program developed a network of nontraditional referral sources that are trained to identify high-risk elders. Gatekeepers can be employees of private business, neighbors, church congregations, housing managers, utility repairmen, newspaper deliverers, taxi drivers or anyone who may come in contact with the elderly population. When an at risk person is referred to the program, a case management team makes contact with the individual, builds rapport, and if possible, conducts a comprehensive evaluation in the home. Services are arranged if needed.

Outcomes suggest that the Gatekeeper Program is successful. The mental health center has seen an increase in the amount of active CMIE clients enrolled in services over the last two decades, from 4% to 26% of the total client base. Data on admissions into the program indicated that only 0.5% of the referrals were self-referred. Spokane has the lowest rate of elderly suicide in the state, 16 per 100,000 elders compared with 24 per 100,000 for WA State. (Knight et. al., 1995)

The Rural Elderly Outreach Program (EOP). Operating from Cedar Rapids Iowa, the EOP provides a delivery of mental health services to the CMIE who are located in rural areas (Knight et. al., 1995). The CMIE who are in rural areas often do not seek the care they need and are often isolated from any service provider. The EOP staff of psychiatric nurse specialists, social workers and psychiatrists, work together as a multidisciplinary team and carefully cultivate relationships with other service providers and community members. Needed support
services are identified and provided in a timely and indirect way through consultation. Several approaches are used in identifying the CMIE in need of medical or social services. The use of psychosocial screening at local sites, such as parish dinners or local cafes can be used. Referrals to the EOP are made through other community service providers and local gatekeepers who are trained to assess and identify high-risk elders. Outreach specialists serve as liaisons between the EOP and other service agencies in the community. By using the indirect consultation model, many more clients are identified using a minimum of EOP staff (3.5 FTE). The EOP maintains ongoing relationships with discharge planners from mental health and health care institutions in the region. Treatments include, screening, testing, physical exam, medication monitoring, psychosocial rehabilitation and short-term therapy of all types. The EOP is based on a highly successful urban model developed by Raschko (1990) and has used many of the same principles. The project was designed to see if the principles could be translated to rural communities. This rural implementation was successful but no specific statistics were cited other than the low FTE of professional staff used by using indirect consultation with an informal community network. (Knight et al., 1995)

The Psychogeriatric Assessment and Treatment in City Housing (PATCH). The PATCH program is an outreach service originating in the Baltimore area that targets CMIE public housing residents who are in need of mental health care (Knight et al., 1995). The PATCH is a proactive mobile model and like the Gatekeeper and Elderly Outreach Program, the PATCH model relies on case finders to identify and locate high-risk residents. The PATCH provides assessment and mental health services, such as case management and brings services to the CMIE in their homes. It provides an educational program to improve case finders’ skills in identifying high-risk elders as well as destigmatizing mental illness. Most PATCH clients live in high-rise apartments and expend more than 50% of their income for housing. Other clients of the
PATCH program may be displaced from previous housing or are victims of exploitation. Social service counselors and other community-based services are available on sight.

The PATCH team consists of two psychiatric nurses and two part-time psychiatrists under the direction of a senior geriatric psychiatrist. Nurses serve as the primary service providers. Nursing staff provides a seven-month education program to public housing staff. The nurses also initiate contacts with residents through community meetings and other activities that involve housing residents. The PATCH program collects information for clinical and research purposes. Data are routinely collected during assessment and during on-going contacts. Nurses provide the initial assessment, which is discussed with the team, and a psychiatrist does further evaluation at a subsequent home visit. With the client’s permission, feedback is provided to the referring person, which provides and encourages on-going communication and support to the referral sources to keep them involved in the project. If the client is able, the nurses link him/her to other community providers for services as needed. (Knight et al., 1995)

In their descriptive study that looked at PATCH interventions, Robbins, Rye, German, Wolfson, Penrod, Rabins, and Black, (2000) conducted a time log study that characterized daily patient-related work activities. The instrument used was the PATCH Nursing Assessment and Intervention Form (PNAIF) that was piloted for one month, revised and used for the time study. Three nurses collected data over four one-month time periods. A PNAIF was filled out for each client contact. A total of 602 contacts were made on 117 residents. Data were analyzed and presented in tables that described characteristics of PATCH clients, their functioning, and referral information. Most importantly a description and table presenting a percentage of interventions used for treatment was illustrated.

The program has a thirteen-year history of outreach to the CMIE. The PATCH model provides mental health services to the CMIE by assessing in the home, engaging them in the
process and maintaining cooperation in treatment by using nursing personnel. The study found that the success of the program is related to education of housing staff members and other caregivers about mental illness, and linking care staff and the CMIE with other community providers. Approximately one-half of the documented interventions from the study involved liaison activities on the client's behalf and forty-four percent involved some type of education activity. Using nurses as staff was found to be part of the success of the program as many CMIE are more receptive and feel less threatened by nurses. Nurses are more aware of the concomitant complex health problems that CMIE often suffer from. The data show that 54% of all PATCH intervention contacts included addressing the CMIE's physical health status or medication regimen or both. Establishing trust with the CMIE is an important key for successful interventions. The authors believe that the PATCH model can be used in other areas where the CMIE need support from the community, such as board and care homes, retirement homes or assisted living facilities. (Robbins et. al, 2000)

Several other community support programs bring together different professional disciplines to provide mental health home services to the CMIE, who would otherwise need residential housing. The Senior Services Program in Ventura, CA was designed and organized by psychologists (Knight et. al., 1995). The programs use a mobile interdisciplinary team of psychologists, social workers, mental health nurses and psychiatrists to screen, assess and treat a broad range of mental health problems in older adults. Emphasis is placed on professional and community education, active case-finding and active assessment and treatment. In this program, psychotherapy is offered to CMIE in their homes if necessary. Case consultation to other community providers is emphasized. The program has expanded to provide day treatment and post-hospital care management. The Geriatric Psychiatry Service (GPS) at the Long Island Jewish Medical Center provides interacting programs based on a continuity of care model. The
GPS oversees two community-based mental health delivery programs for the elderly. Cape Homebound provides psychiatric and psychological treatment to older persons in need of mental health services who are homebound because of medical illness and functional disability. Academic and research endeavors play a prominent part of GPS (Knight et. al., 1995).

Alternative Residential Facilities

Long Term Care Alternatives in Western Massachusetts. As part of state mandated deinstitutionalization of its state psychiatric hospitals in 1979, a continuum of residential care for the CMIE was established. In the next decade a classification of rest homes (a cross between a nursing home and a board and care home) were established that had three categories: 

a) conventional homes that took no CMIE, b) conventional with Community Support Residents, which took less than 50% CMIE and c) Community Support Facilities with 50% or more psychiatric residents. Only rest homes classified as a Community Support Facility are permitted to freely admit CMIE.

Community Support Facilities provide a mix of professional staff to insure that the CMIE receive appropriate services. These include a licensed Social Worker who sees clients one hour per month and oversees a Mental Health Treatment Plan, and a full-time Support Services Coordinator with a minimum of a Bachelor Degree in a human services-related field, who sees clients on a ratio of 1:20. The two staff work as case manager and treatment coordinator. They implement an Individual Service Plan, which outlines rehabilitative goals. Supervision is increased at night. Increased training and experience in mental illness in the elderly, crisis intervention, medications, and client rights are required of these facilities, which receive a higher rate of reimbursement. (Mosher-Ashley and Henrikson, 1993)

The Domus Philosophy. The domus philosophy of residential care was developed in inner London to replace traditional long stay mental hospital provision for the elderly with
dementia and the CMIE. The housing option was based on the four assumptions that the domus is the residents' home for life, that the needs of the staff are as important as the residents', that the domus should work to prevent avoidable consequences of dementia and accommodate those consequences that are unavoidable, and lastly, that emotional needs may take precedence over certain aspects of physical care. The emphasis of the domus is to maintain independence of the residents as long as possible.

A prospective study, published in 1993, was conducted in the first year of operation of two domus (housing) units for elderly people. The study was modeled after the original study by Lindesay in 1991 of the Domus philosophy (as cited in Dean, Briggs, & Lindesay, 1993). The two housing units had different elderly populations. Domus A for elderly residents with dementia and domus B for CMIE residents with schizophrenia. Each domus was built for 12 residents. All residents in domus B were CMIE over 65 years of age that had been in continuous psychiatric care since before the age of 65. Sixteen full-time and one part-time staff operate the facility with four staff during the day and two at night. Residents and care provision were assessed at baseline from the hospital ward, at three months, six months and twelve months after their move to the domus. The evaluation took place from Nov. 1989 to Aug., 1991.

The instruments used in the study were: a) The Policy and Program Information (POLIF) section of the Multi-phasic Environmental Assessment Procedure (MEAP) to monitor evolving policy of the domuses. b) The Organic Brain Syndrome (OBS) scale of the CARE schedule to measure cognitive impairment. c) The Depressive Signs Scale (DSS) to measure levels of depression, and d), the Adaptive Behavior Rating Scale (ABRS) to measure residents' self-care skills, mobility, mental, and social functioning. Each of the scales were administered or rated by appropriate researchers or staff. All of the assessments were performed at each follow-up point. Objective quantitative data about social interactions and activities were collected using the Short
Observation Method (SOM). Data were appropriately analyzed using SPSS+ with differences in the POLIF scores analysed by the Cochrane Q test (Dean, et. al., 1993).

At 12 months, both domuses were providing more policy choice, resident control, provision for privacy, and had more social and recreational activities available than at baseline. The cognitive function of the residents improved steadily over the follow-up period. Activities of daily living (ADL) improved. Depression scores were slightly elevated by domus B at three months, but returned to baseline at six months. Communication skills were improved at six months and compared to baseline, substantially higher levels of activities and interpersonal interactions were observed at follow-up.

The increase in depression in domus B at three months suggests and confirms previous findings that this group may be more vulnerable to changes in living situations. Based on the domus philosophy, domus B, at 12 months was taking longer to achieve operational policies than domus A. Interactions between residents in domus B fell following the initial move. It took six months to note significant reductions in sitting and concomitant increases in organized and unorganized activity and staff/resident interactions. This data suggest that as a result of being institutionalized it may take the CMIE a longer period of time to adjust to new situations (Dean, et. al., 1993).

The study reinforces the findings from the previous study by Lindesay et. al., (1991) (as cited in Dean et. al., 1993) that the domus philosophy provides greater opportunities for choice and control, more privacy and has more social and recreational activities readily available. The authors mention that two other studies by Picard, Clifford, and Walsh (1989), and Picard, Proudfoot, Wolfson, Clifford, Holloway and Lindesay (1992), had also studied Domus B as part of a prospective evaluation of the closure of one of the long-term hospitals (as cited in Dean, et. al., 1993).
The study confirmed that the residents had a higher level of global social functioning at 12 months post hospitalization.

**TAPS Project.** The Team for the Assessment of Psychiatric Services (TAPS) has conducted on-going studies for two psychiatric hospitals, Friern and Claybury, in London. The most recent study done by Wills, Trieman and Leff, (1998) compares aspects of care given to CMIE in a traditional hospital setting and alternative community based facilities. Four perspectives were examined. They were relatives’ views regarding the quality of care in different residential settings, observations of daily routine, social interactions and other activities in the settings, and staff members’ points of view. These included comments regarding the milieu, their roles as caregivers, training issues and job satisfaction, and the physical outlay of the facility. Domestic staff and administrators were excluded from the study.

Seven hospital wards from Friern Hospital and four community facilities, which received former residents of Friern Hospital, were selected. The first three questionnaires consisted of the MEAP tool. In addition, the Nurses Aid Questionnaire solicited professional background and attitudes of care staff toward their work, the Minnesota Job Satisfaction Questionnaire (MSQ), and a training needs checklist were also used. Percentages with mean scores were compared between the two categories of settings.

In the findings, community settings were superior to the hospital units in providing more privacy for the residents and were better equipped with physical amenities and safety features. Staff from community settings encouraged more independence in the residents. Shifting away from a medical model of care in community-based homes was beneficial to the CMIE, as long as their physical needs were being met. Staff from community settings could have benefited from clearer policies and more training. (Wills, et. al., 1998)
In 1996, a similar study by Wills and Leff looked at the same CMIE population that was discharged from Friern and Claybury Hospitals into community settings. They compared the quality of life in the hospital with that in community residences. Views of hospital patient relatives and community residences were studied. Observations were made in both settings. The authors found that the average time spent in social contact was greater for the community residents. This was also the perception of the relatives. When summarizing the pertinent differences between hospital and community settings all areas that were observed showed significant differences in favor of the community setting. (Wills & Leff, 1996)

**Therapeutic Foster Homes for Elderly Mentally Ill Persons.** Cited in Volume 45 of the Hospital and Community Psychiatry Journal as having received a Significant Achievement Award, the Alternative Family Program provides the CMIE a long-term homelike environment with receptive and accepting families ("Therapeutic Foster Homes", 1994). Gulf Coast Community Care, a non-profit organization of Tampa Bay, Florida, started the Alternative Family Program, a residential alternative for the CMIE. The program uses carefully screened and trained caregiver-sponsors from the community to provide housing and intensive support for up to three CMIE residents. The Alternative Family Program is responsible for recruitment and training of the caregivers. With the program’s assistance, the caregivers become licensed by the state as foster care providers. The program matches the CMIE resident, usually from a state or private psychiatric facility, with the caregiver. The caregivers help connect the CMIE to other community supports. CMIE who have been placed in the homes have had a less than ten percent rate of return to the state hospital.

The Alternative Family Program is one of several that Gulf Coast Community Care has started since 1960. It has developed a continuum of community based mental health services as alternatives to long-term institutionalized care. These services include a geriatric residential
treatment system, mental health support in nursing homes, and a geriatric mental health support team that provides training and supportive services for caregivers of elderly mentally ill persons.

Once placed with a sponsor family, the CMIE may remain until their physical condition deteriorates and they require a more medically supportive setting. Placement is voluntary and the resident can leave at any time. The program is designed to provide permanent housing. The caregiver sponsor provides day-to-day care and support and is active in the resident's treatment process. Families who are caregiver-sponsors must be functional with working family members who are not financially dependent on the stipend from the resident and must own their own home. The program provides staff for supervision, support and back up. Professionals provide needed consultation and evaluation as necessary.

Program funding comes from federal state and local governments, private foundations and donations, client fees and third-party billings. Initially the program was expanded through funds made available by downsizing the state mental hospitals. The Alternative Family Program began in September of 1991, has served 118 persons and has trained and licensed as many as 75 sponsor families ("Therapeutic Foster Homes", 1994). This is an interesting model that holds promise for future development of residential alternatives for the CMIE. It involves collaboration among different funders and funding categories.

Supported Housing for CMIE. Supported housing emphasizes the development of normal housing options linked with supports that are flexible and individualized. Supported housing should be agreeable to the tenant and be able to meet normal community standards. It should be permanent or available for as long as the tenant can remain. It should be accessible to community resources and affordable. (Carling, 1990)

In Washington State, Sohng (1996) took 50 clients who were in danger of being displaced from two nursing homes by the OBRA provisions, and placed them in supported
housing. Eighty-four percent of the clients were over 50 years of age. The qualitative study had three collection points, at startup, and at six and eighteen months later. The author noted a frenetic start-up, as there was considerable pressure to spend left over money from the state's biennium. The study focused on the process evaluation findings in three areas, which were the development of normal housing, the support element and consumer choice and preference. Perspectives and experience of both consumers and caregivers were sought. Participants included consumers and family, staff, government representatives and nursing home administrators. Data were collected through open-ended interviews by qualified researchers. The constant comparative method of qualitative data analysis was used. The narrative data were supplemented with internal documents, reports, and records when appropriate. The authors noted that the program was in the process of being implemented and constantly evolving while the evaluation was taking place.

The consortium working on the project generally followed the guidelines for type, location, and cost explained above. Finding housing was difficult. The clients paid 33 to 35 percent of their income on rent. The housing provided was a two-person, two bedroom apartment in multi-unit buildings dispersed in six different sites. Each complex included four apartments, three for clients and one for staff, which included residential counselors, a case manager, a psychiatrist and a nurse. There were recreational facilities on site. The apartment complex was conveniently located to offsite amenities and bus transportation was available.

Several themes were highlighted from this process. Consumer choice remained a complex issue throughout the course of implementation. Historically, change is difficult for the CMIE and being pulled from an institution where they may have lived for years was viewed as undesirable for many residents. Due to time constraints to move the project along, the clients did not have choices of where they would live, nor did they have time to make many of the initial
decisions that created a huge impact in their lives. This was done for them. Once placed in the
apartment and given a variety of choices for the first time in many years, some of the residents
became overwhelmed. Initially fear and pessimism were seen in the start-up interviews, but this
changed as residents and staff accepted and used the newly discovered freedom to make choices
on a daily basis. By the end of the first year, however, 46% of the original group stayed in the
nursing homes. Families and residents simply did not want to leave the nursing home setting.
(Sohng, 1996)

This example of supported housing for the CMIE is fraught with technical problems.
Initially, it appeared the program was thrown together quickly so that money would not be lost.
The authors indicated that the OBRA officials gave lip service to client choice, but when faced
with going or not, clients were pressured to try the living alternative without much preliminary
planning. Noted in the study was the high level of medical staff hired for the project to oversee
the medical needs of the residents. A .7 FTE psychiatrist for less than 50 residents appears
excessive. Three full-time registered nurses also seem excessive, unless medical treatment,
which was not described, was provided at home. Staff apartments for every three apartments of
residents also appeared excessive in cost, if the apartment was fully staffed. Finally the author
indicates that if the residents were doing well, they risked the possibility of being moved out into
conventional underfunded residential programs, which goes against one of the basic principles of
supported housing illustrated in the beginning of this sub-section. More research and pilot studies
are needed to test the principles of supported housing for the CMIE population.

Colby House. This residential alternative seems to make some of the changes that were
needed to make the previous Supported Housing for the CMIE alternative successful. The Colby
House, which requires licensure as a board and care facility in Washington State, and receives
support from two state funders, the Department of Aging and Department of Mental Health, has
shown promise for the CMIE. The Colby House is one of three board and care homes operated by a private owner. The owner requested six female CMIE clients that were considered challenging to work with. Six women were chosen from the community who were considered ‘failures’ in the residential arena. One woman was 40 years old and the other five were over sixty years old. Active client participation in choice of home, location and furnishings was desired. The women were involved in the selection of the residence. Each had the choice of her own room, and each was involved in the selection of the furnishings. The house selected was a ranch style brick house in a setting on a bus-line where community resources are nearby. The house has alarms on doors that are set at a specific time each evening.

The home has 24 hour staffing that includes certified nursing assistants as the main staff. Two staff members are on duty during the day and one staff member at night. The night person has a private room and is allowed to sleep, but is readily available if needed. All staff receives specialized training in working with the CMIE. The staff has the option of rotating to the other two facilities if they experience burn out.

The clients are linked to mental health services in the community. The services of an evaluation and treatment (E&T) facility are available if any of the clients experience an exacerbation of their mental illness. The program has been in existence for nine months. During that time two episodes have occurred that require treatment at the E&T facility. (Susan Fleskes, R.N., B.S.N., WA State Medical Assistance Administration, Personal Communication, 3/12/01)

Colby House is an example of what local communities can create when private and public sector entities work together. It is too soon to evaluate whether this type of alternative housing for the CMIE will have a lasting impact. Upon initial examination it appears cost effective and well accepted by the residents.
Elder Options. A subsidiary of ReVisions Behavioral Health Systems, Elder Options was created as a response to the unmet needs of the CMIE who may also have physical illness. With funding from state hospital downsizing and HUD money, Elder Options purchased a home for eight CMIE in a residential neighborhood. The home has a pool that is used in the summer for hydrotherapy and resistive exercise. Staffing is comprised of licensed practical nurses as opposed to rehabilitation specialists. In the seven months it operated prior to the writing of the article, the author reported not one single elderly, fragile resident has had to be reinstitutionalized. The daily cost was reported to be $47.00. Elder Options is in the process of opening another residence. (Cromwell & Graham, 1998) No research or other informational detail was noted in the article.

Comprehensive Psychogeriatric Assessment

Upon referral of the CMIE for community support or alternative residential placement, a comprehensive psychogeriatric assessment is the cornerstone of effective psychogeriatric care (Department of National Health and Welfare, Ottawa, as cited in Cyr & Peppler, 1995). A holistic approach to the assessment should promote harmony in both the mental and physical aspects of healing (Kutlenios, 1987). It is important to include in the comprehensive assessment, screening tools that differentiate mental illness from dementia, and assess for depression and functionality.

Necessary components of the psychogeriatric assessment

The psychogeriatric assessment should include all of the components of a regular adult psychiatric evaluation that are recommended by the American Psychiatric Association. In Table 1 a summary of the important components that are recommended when doing a psychogeriatric evaluation are listed. The recommendations come from guidelines that were introduced by the Department of National Health and Welfare, Ottawa (as cited in Cyr & Peppler, 1995). Also
included in Table 1 are areas that may be included in the regular assessment for adults, but are of particular importance to the geriatric client.

A team of professionals that includes a psychogeriatric nurse practitioner or psychiatrist who is qualified to diagnose, order necessary tests, and recommend treatment should do the assessment. Also included in the team are a geriatric mental health specialist and a medical case manager/social worker. It is not necessary for all of the team to be present during the whole process. It should be done in a comfortable surrounding, preferably in the client’s home.

**Assessment Screening Tools.** The following is a description of several studies that examined the effectiveness of screening tools used to assess the CMIE.

(a) A functional assessment that includes activities of daily living (ADLS) and instrumental activities of daily living (IADL) should be done as part of the assessment process. In a study of elderly clients with schizophrenia and bipolar disorder, Bartels, Mueser, and Miles, 1997, found that more severe functional deficits and lack of social support were the key differentiating features of nursing home clients compared with community-residing CMIE. They found the prominence of functional deficits over symptoms and behavioral problems was a stronger indicator of residential placement. Additional studies have indicated that lower Global Assessment of Functioning (GAF) scores, as opposed to active psychosis and other mental health symptoms, more accurately predict whether the client will need intensive support and monitoring such as residential placement. (Kennedy, Madra, & Reddon, 1999) (Ponce, Molinari, Kuni, Orengo, Skinner, Rezabek, Okezie, Khalsa, & Workman, 1998) The functional assessment should include a GAF scale. (Endicott et. al., 1976)

(b) An appropriate screen for dementia is essential; as it is particularly difficult to assess the CMIE for signs of dementia as the progression of certain mental illnesses, such as schizophrenia, because they often display some cognitive deficit, which can easily be mistaken
for dementia. It is important for the evaluator to know that dementia in elderly schizophrenics appears gradually. Harvey, White, Parella, Putnam, Kincaid, Powchik, Mohs, and Davidson, (1995) used the MMSE in a longitudinal study of cognitive impairment in geriatric schizophrenics (Folstein, Folstein & McHugh, 1975). Average MMSE scores did not change over a one or two year follow-up period. The test-retest reliability was extremely good at both retest intervals. The results intimate that cognitive changes in geriatric elderly schizophrenic clients are very slow and are more consistent with a neurodevelopmental process than a neurodegenerative course. The study found that the average drop in MMSE points was three per decade, which the authors point out, is consistent with previous studies (Harvey et. al. 1995).

Several studies have pointed out the importance of proper assessment and the use of the right screening tools when assessing for dementia in elderly schizophrenics. In a study done by Harvey, Davidson, Powchik, Parrella, White, and Mohs, (1992) the importance of using all available sources of information when screening for dementia in schizophrenic clients was underscored. Harvey et. al. compared assessments of chronic elderly schizophrenics using three screening tools, the MMSE, the Clinical Dementia Rating (CDR), and the Alzheimer’s Disease Assessment Scale-Late (ADAS-L). The raters either used the chart alone or used suggested sources, such as the patient, caregiver and chart. Interater reliability of the ratings from the latter, combined sources, was very high. Most of the 20 items scored above 0.80. When the ratings were generated from the chart alone, without contact with either the patient or caregiver, there was noted to be a systematic bias toward overestimation of the severity of dementia. The results suggest that specialized tools are not necessary when assessing dementia in schizophrenics, and that relying on the medical chart alone would induce a systematic bias in the results. (Harvey et. al, 1992)
In a study that looked at the use of cognitive abilities screening tools for schizophrenics, Sherrill, Buckwalter, Bode and Strozdas, (1999) confirmed Harvey et. al.'s (1992) findings that a specialized tool is not necessary to detect dementia in schizophrenics. Sherrill et. al. compared screening tools for effectiveness and sensitivity in detecting dementia. The relevant study compared the MMSE with the Cognitive Abilities Screening Instrument (CASI) (Teng et. al., 1994). The authors found both tools to be valid in the classification of dementia, but the CASI was more precise in assessing the level of cognitive impairment and provided more comprehensive data than the MMSE. The authors suggest that the information from specific domains could be used to establish more individualized plans of care based upon more clearly defined strengths and weaknesses of the client. The usefulness of administration of a subset of CASI domain scores to assess cognitive impairment was demonstrated by the results. The authors discuss whether the administration of the total CASI or the three “most sensitive” domains, which were orientation, short-term memory and fluency, would depend on the intent of the assessment. If a quick screen for dementia is needed, the administration of the most sensitive domains of the CASI should produce a similar estimate of cognitive impairment as the total score of the CASI. If a profile or more precise assessment is wanted the whole CASI should be administered. (Sherrill et. al., 1999)

(c) Depression screening is important in the CMIE as often, depressive symptoms are masked as dementia and show up as concentration deficits. There is a tendency to under-diagnose and under-treat depression in the geriatric population, which may be due to the mistaken attitude that depression is a normal part of aging. (Feldman et. al., 1987, as cited in Bair, 2000). It is important to distinguish other medical disorders from major depression and to be aware of medical illnesses that are associated with depression. Certain medications can have depressive actions. It is important to keep in mind that the symptoms of depressed mood do not have to be
present to meet the criteria for major depressive disorder as long as diminished pleasure is
described. The Geriatric Depression Scale (GDS) is an evaluation tool that is widely used and is
a reliable and valid screen for depression in older adults (Yesavage et. al., 1982-83). With a score
of 11 or greater this 30-item test has a sensitivity of 84% and a specificity of 95% for depression
and can be used in an observer-administered format. (Yesavage et. al., 1983-83). A shorter 15-
item version of the GDS is available (Sheikh & Yesavage, 1986). Using an optimal cutoff score
of 5-6 the short form GDS showed a sensitivity of 85% and specificity of 74%. The short form
GDS is self-administered and takes approximately five to ten minutes to administer. (Herman et.
al., 1996)

In summary, a comprehensive mental health assessment and screen for the CMIE will
assist the psychogeriatric team in determining what is the best course of support and treatment. A
holistic approach ties in the physical, emotional, and environmental factors that embody the
client’s existence. By tying these factors into a plan of care, the CMIE client will get the
treatment that is most appropriate and as self-directed as possible.

On-going Clinical Consultation with an Advanced Practice Nurse

Once the CMIE client is evaluated and placed in an appropriate residential setting, it is
valuable to continue implementing the holistic approach to the initial recommendations for
treatment. Nurses have a unique knowledge base that allows them to consider physical,
emotional and environmental factors that may affect the CMIE stability and balance. Mental
health work with the CMIE should include a knowledge base in differential diagnoses of medical
and mental conditions. Psychiatric mental health nurse practitioners have this precise expertise
that makes them uniquely qualified to treat and educate on psychogeriatric issues. There is a
paucity of research in the area of psychiatric nursing providing needed assessment and
consultation concerning the CMIE population. Nurses who describe the experience of being a
psychogeriatric consultant write a number of articles, but only a few studies have been done that look at the value of advance practice nurses in the consultation and evaluation role. Providing direct or indirect consultation to staff and other treatment providers around psychogeriatric issues in residential facilities and consultation resulting from direct referrals for evaluation of CMIE clients are briefly summarized from two studies in the next sub-section.

Staff Consultation Model

Results from a consultation survey that was collected as part of a larger geriatric mental health training project support the idea of geropsychiatric nursing consultation services to staff in LTC facilities as an important adjunct to training (Smith, Mitchell, Buckwalter, & Garand, 1995). The consultation service used advanced practice geropsychiatric nurse specialists as the trainers for nurses and nursing administrators in a train the trainer model on geriatric mental health topics related to LTC. After the initial series of training, the consultant provided case consultation and technical assistance to participating facilities in person and by phone at no charge. The consultant did not provide problem-solving strategies to particular cases or direct assessment or service to the residents, which is considered client centered. Instead, the consultant encouraged independent problem solving and focused on the consultee’s perception of the problem. This is considered indirect or consultee-focused consultation.

Data from the surveys showed that the training was viewed as successful, however a smaller than expected number of staff nurses used the indirect consultation (38%). Upon checking the records from the consultant, however, more contacts were logged than were noted on the returned surveys. Some of the LTC facilities used the service, but failed to return the survey. Some staff of LTC facilities misunderstood the indirect approach to service. A few felt that the consultation would be direct problem solving of a client issue by the consultant, or expected the consultant to provide the facility with a standardized care plan and expressed
dissatisfaction with the model. Another example of misunderstanding of the model was of several LTC nurses questioning whether they needed a ‘doctor’s order’ for the consultant to provide the indirect consultation to the facility. Other nurses reported that they felt it would reflect badly on their competency to ask for consultation on how to do something they supposedly were trained to do. Of the staff that used the consultation most (89%) agreed that the consultant understood their problem and 97% valued the consultation. All agreed that they would use the service again (Smith et. al., 1995).

Based on the results of the survey it is important to educate administrators and LTC nurses of the difference between client centered and consultee-centered consultation. The authors recommend that the importance of nurse to nurse consultation should be emphasized throughout nursing curriculums (Smith et. al., 1995).

Direct Consultation Model

Several studies have examined the value of nurses providing direct assessment and consultation of the CMIE to community providers. One study evaluated effectiveness of nurses as evaluators and providers of treatment in a community support model called PATCH, that was described in another study in an earlier section of this paper. (Rabins, Black, Roca, German, McGuire, Robbins, et.al., 2000)

Only one study was found examining nurse practitioner consultation to residential facilities. The study done by Eisch, Brozovic, Colling and Wold (2000), looked at outcomes of nurse practitioner psychiatric consultation to nursing homes in a New York middle-class low-density area with an elderly population nearing 20%. Five nursing homes participated and had previously identified problems in receiving on-going psychiatric help for residents with behavior problems. Nurse Practitioners (NP) were contacted for consultation by nursing staff, social workers, physicians and family members. The reasons for the referral were most often changes in
a resident’s behavior. All referrals needed approval by the resident’s primary care physician to permit third party billing. Qualitative evaluation was provided by using twenty audio-taped focus groups at each nursing home. Analysis of the transcribed data used Colaizzi’s Phenomenologic Method from a psychological evaluation method developed by P.F Colaizzi (Valle & King, eds, 1978 as cited in Eisch et. al., 2000). Positive behavioral changes were effected in 62% of the residents. Primary physicians, staff, and administrators validated that the strategies provided by the NPs were effective. The year-long demonstration project demonstrates that nurse practitioners with specialized training in geropsychiatric issues can recognize and treat depression, delusions, and delirium. They can work effectively as consultants in collaboration with the nursing home and attending physicians. The consulting service continued after the demonstration project ended and expanded to ten nursing home sites for four NPs working collaboratively with a geriatric physician. (Brozovic et. al., 2000)

Conclusion

The CMIE are a subset of a population that is already chronically stigmatized and underfunded for adequate treatment. As our elderly population continues to increase in numbers, mentally ill persons also continue to age and become dependent on society for community support. The need for LTC facilities will increase. The CMIE have unique needs that have been historically unmet in traditional community support and LTC facilities for the general population. The literature reviewed in this paper reveals that minimal support is available from the private and public sectors to adequately fund alternatives that can meet the current housing and mental health needs of the CMIE, let alone those of the future.

Several common themes were found in the literature that demonstrate the CMIE have unique residential care needs. Research shows that for successful residential placement the CMIE should have adequate preparation time and verbal input when planning a residential
change, as unplanned relocation is often associated with functional and mental status decline in this population.

Research studies have demonstrated the following areas to be important considerations when looking at residential options for the CMIE. One is a physical environment that has flexibility of daily routines and services, more policy and personal choice, and more provision of privacy. Implementing this type of environment promotes increased adaptive functioning, increased socialization, and enhanced cognitive ability in this population. In environments where residential policies are less restrictive and peer residents are more functional, the CMIE are more independent. Residents who receive personalized treatment from staff experience enhanced functional ability.

Another is linking community members to professional geropsychiatric teams. This has proven to be a successful way to provide services and support to the CMIE living in their own homes. Programs that use education and a combination of community supports and providers in tandem have successfully kept the CMIE in their own homes longer. The programs are all geared towards establishing trust with the CMIE.

To satisfy budgetary considerations, new opportunities for alternative housing and intensive community support are sometimes asked to start up too quickly, often with little forethought. This is because when financial opportunity arises it often arrives without time for proper planning. The project gets eliminated when outcomes are not reached, which may be due to unrealistic timeframes, disappearance of funding, or a variety of reasons that are unclear. We, as health care professionals must be ready with options for the CMIE, which are well thought out and timely. Alternatives to traditional housing and community support to CMIE living independently have been researched and proven effective when based on adequate human and
financial resources. The identified themes outlined above are important for the continuing
stability of the CMIE in their homes, and should be included when planning residential options.

Several effective screening tools were found to be helpful for the assessment of the
CMIE. Evaluating the functional status of the CMIE is an important consideration when
considering a residential placement. Research has shown the presence of environmental aids can
support or hinder the resident depending on their level of independence. Instead of evaluating the
CMIE's active psychosis or other mental health symptoms, scores from the GAF more accurately
indicate the type residential placement needed. Dementia in the elderly schizophrenic is gradual.
When assessing for dementia in elderly schizophrenics many specialized tools are not necessary,
but it is essential to evaluate the client face to face. Research found that the CASI and the MMSE
were both valid in classifying dementia, but the CASI was more precise and provided more
comprehensive data than the MMSE. A subset of CASI domain scores was found to be most
sensitive in assessing cognitive impairment. The Geriatric Depression Scale (GDS) was found to
be a quick, effective, self-administered tool used to assess for depression in the CMIE.

The role of the mental health nurse within many community health settings is poorly
defined and researched. The scope of practice of the psychiatric nurse is a well-kept secret that
needs to be made much more visible. It is a resource that should be shared and utilized. Nurses'
holistic view of humanity allows for a comprehensive assessment and intervention that includes
expertise in social problems, the health and illness continuum, and health-care management
strategies (Talley & Coleman, 1992). In the psychogeriatric field, nurses are an underutilized
professional group that can fill the gaps of unmet needs of the CMIE in areas of evaluation,
problem solving, and treatment in a way that is unique to all other professions. Out of the studies
available, research demonstrates that the advance practice nurse is also effective in the role of
consultant. If nurses realize the strength of their own profession, there can be a continuum of
holistic care and collaboration within the nursing field that the nursing profession frequently
does not recognize, acknowledge or utilize to the fullest extent. If nurses realize the strength of
their own profession, they can provide appropriate treatment and support to the CMIE. Nursing
will benefit by promoting advance practice, and the CMIE by having their needs met in a real
home in the twenty first century.
References


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Omnibus Budget Reconciliation Act of 1987 (OBRA-87), Public Law N., pp.100-203.


Table 1

Additional Components that Contribute to a Thorough GeroPsychiatric Assessment

ASSESS:

- The client’s perceived needs, strengths and preferences. Include perception of health.
- The physical environment that includes barriers to services and safety risk.
- Exercise habits and access to recreational resources.
- Financial and legal resources after trust with the client is established. Client’s perception of finances.
- Support network. Include community and social supports.
- Medical history that provides a comprehensive screen for delirium and includes ALL medications including:
  - OTC drugs
  - Herbal remedies
  - Vitamins
  - Alcohol
  - Caffeine
  - Nicotine
- Sleep disturbance*
- Routine lab work and accessibility to lab drawing stations

* Sleep disturbance occurs in as many as 30% of community elders (Consensus Development Conference, 1990 as cited in Bair, 2000).