Nursing Homes and Chronic Mental Patients: A Second Opinion

by Paul J. Carling

Abstract

Through a critical review of Shadish and Bootzin’s (1981) work in “Nursing Homes and Chronic Mental Patients,” the author defines the larger context in which this national problem occurs, presents important distinctions among various subgroups of nursing home residents, and summarizes some of the most glaring historical inadequacies of using institutions as the core of a mental health system. Through this approach, the presentation raises serious questions about Shadish and Bootzin’s proposal to use nursing homes as a foundation on which to reconstruct an improved community services system for chronically mentally ill persons.

William Shadish and Richard Bootzin’s (1981) article “Nursing Homes and Chronic Mental Patients” reflects a great paradox in the history of “deinstitutionalization.” Although large numbers of public psychiatric hospital patients were discharged and “transinstitutionalized” to nursing homes over the last two decades, we know discouragingly little about the unique characteristics, needs, and potentials of this group. We do know that, by and large, they are not receiving the mental health and, as importantly, the rehabilitation services they need primarily because the institutions in which they reside are inadequately linked to the formal systems of community services in mental health, health, housing, employment, and other critical areas. Many should not have been placed in nursing homes in the first place, yet few will leave because the fiscal and reimbursement incentives operate simultaneously to impoverish the resident and promote the institution’s interest in long-term, in fact, terminal, residence (Wack and Rodin 1978; Public Health Service 1980).

Despite this complex set of problems, the authors propose a greatly enhanced role for nursing homes in the mental health system. Certainly there does need to be a much more rational and systematic relationship between mental health care—indeed the full range of community-based human services—and these institutions. Any proposal for the form which this relationship should take and for the relative importance of nursing homes in such a system, however, must take into account several dimensions of the problem that are not adequately addressed in the Shadish and Bootzin article. Specifically, it is critical to consider:

• The variety of subgroups of chronically mentally ill persons both in nursing homes and in community settings;

• Policy issues in mixing mentally ill persons of varying ages and elderly persons with no history of mental illness;

• Changing trends in the use of nursing homes by mentally ill persons;

Reprint requests should be sent to Dr. P. J. Carling at Appletree Point, Burlington, VT 05401.

The views expressed herein are entirely those of the author and do not reflect the policy or position of either the National Institute of Mental Health, the Department of Health and Human Services, or the Vermont Department of Mental Health.
• The great variability between and among nursing homes; and
• The limits of the "total institution" concept.

The Department of Health and Human Services recently completed a major undertaking that had been recommended by the President's Commission on Mental Health (PCMH). Staff of the National Institute of Mental Health and the Health Care Financing Administration, with assistance from many other HHS agencies, as well as other Federal departments, consumers, and professional groups, produced a comprehensive analysis of the number, location, needs, and potentials of the population of chronically mentally ill persons. Within this context, the "National Plan" identified a broad range of improvements needed in the financing, organization, and delivery of "community support services" and proposed a series of incremental program and financing reforms. This document, Toward a National Plan for the Chronically Mentally Ill (Public Health Service 1980), focused on specific subgroups such as severely disturbed children and adolescents and elderly persons, as well as those in nursing homes. The findings and recommendations of the National Plan will be discussed below, in part, within the context of Shadish and Bootzin's presentation.

What Is a Nursing Home?

While it is relatively easy to distinguish between a Skilled Nursing Facility (SNF) and an Intermediate Care Facility (ICF) in terms of the degree of medical supervision, it is important to keep in mind the great variability of these facilities. Since the critical distinction is one of nursing care levels, established without regard to the numbers of mentally ill persons in either facility, it is difficult to generalize about the services programs or their appropriateness for mentally ill persons in these institutions. We do know that the provision of mental health services is grossly inadequate. In fact, the National Plan points out that, in spite of the extent of mental disorder among nursing home residents, there are no certified nursing homes in this country with a full-time psychiatrist on staff, and very few employ psychiatrically trained nurses.

Within the field of mental health, the term "intermediate care facilities" is used to describe facilities ranging from halfway houses to institutions for the multiply handicapped. The PCMH called for a new intermediate care program in mental health to parallel that developed for mentally retarded persons (ICF-MR), thereby provoking considerable discussion in the field as to what kind of facilities such a program should develop (e.g., small community-based institutions such as group homes, halfway houses, or cooperative apartments) or, in fact, whether it would be more appropriate to define intermediate care in mental health in terms of the range of services and life opportunities needed, regardless of setting or facility (e.g., case management, employment-related activity, crisis stabilization, and advocacy). To overlay the current nursing home organization, developed historically for an aged and infirm group, on the needs and potentials of chronically mentally ill persons would, it seems to me, be a grave error, particularly when we are just reaching the point of consensus on how to define and begin meeting the multiple needs of, and providing life opportunities for, individuals of this latter group.

Who Are the Mentally Ill In Nursing Homes?

If nursing homes are variable, their residents are infinitely more so. In determining improvements needed in nursing homes and their place in a reformed mental health system, one must first distinguish among residents; some were inappropriately placed there for reasons of reimbursement or because no other shelter was available; some entered with a primary diagnosis of mental illness; some are young and clearly nonsenile; some became mentally ill after admission; and some were admitted with a diagnosis of simple senility. It is only by distinguishing among these subgroups that we can begin to define the unique problems and needs of those mentally ill persons who appropriately reside in nursing homes as contrasted with the larger mentally ill population.
To propose that a system be organized around a set of facilities simply because so many of the "target population" are in those facilities overlooks both the problems of what proportion should be there and whether the facilities in question can meet their needs. It might be useful at this point to summarize the major differences among nursing home residents as developed in the National Plan. In 1977, of a total of 1.3 million residents in certified nursing homes, about 20 percent had a "primary mental disorder" (depression, presenile and senile dementias, psychoses), an additional 8 percent were potentially primarily mentally ill (based on secondary diagnoses and underreporting), and nearly 30 percent were classified as senile without psychosis. The remaining 40 percent were not mentally ill but were at risk of becoming so. Of all residents, fewer than 8 percent were former public psychiatric hospital patients. Moreover, 14 percent were less than 65 years old (Public Health Service 1980).

**Nursing Homes: Can They Meet the Needs of Both Aged Persons and Mentally Ill Persons?**

Shadish and Bootzin avoid one of the most controversial issues in considering the role of nursing homes in the mental health system: should mentally ill persons be served in institutions designed for a different group? Although the symptoms of senility may at times be similar to those of mental illness, and although senile individuals may share with mentally ill persons a high level of dependency at particular times, there are some fundamental differences in services needs between those who have functioned satisfactorily for most or all of their prenursing home lives and those who have spent months or years struggling for functional self-sufficiency. To cite the most obvious example, one of the major needs of chronically mentally ill persons is for that array of services loosely termed "psychosocial rehabilitation," including supportive vocational and housing opportunities. Nursing homes are not oriented toward such a rehabilitative approach for the excellent reason of the financial disincentives to having residents move out to greater independence (Kohen and Paul 1976; Wack and Rodin 1978). As critical is the implicit message to a mentally ill person on entering a nursing home: "You have come here because you are no longer able to take care of yourself; people come here and stay here until they die."

**Changing Trends in Discharge Data**

Large numbers of patients discharged from public psychiatric hospitals were "transinstitutionalized" to nursing homes, but it cannot be assumed that this trend has continued unabated. Only 8 percent of current certified nursing home residents were placed there from such hospitals. Further, recent scandals in board and care homes point up that many residents in these settings need higher levels of care but were placed there because nursing home beds were unavailable. Thus, we are faced with a situation in which many who are in nursing homes need not be there, while many who are not need something akin to the level of care that nursing homes provide. We also know that in several States the proportion of persons discharged "to family" has declined while discharges to board and care homes and more independent settings have increased.

Our data needs in regard to nursing homes are extensive, yet the major argument used by Shadish and Bootzin to bolster the importance of nursing homes in the deinstitutionalization process is supported by general estimates of admission and discharge data, such as that pertaining to general hospitals, and, as mentioned above, ignores changing trends in these data. Thus, their estimates may inappropriately exaggerate the current importance of nursing homes in the overall discharge picture. Additionally, it is impossible on the basis of existing data to make the critical distinction between those mentally ill persons who are placed in nursing homes appropriately and those who are placed there simply because of bed availability. Further, current data make it hard to distinguish between those persons who were mentally ill upon admission, often diagnosed "senile with psychosis," as distinguished from those who became "mentally ill" after admission (senility with or without psychosis). The failure to point out the serious shortcomings of the data and to draw these kinds of distinctions leads to a lack of clarity and an inability for the reader to determine just who is being described as "the mentally ill in nursing homes."

There is also some confusion between the number of dollars spent...
on institutional versus community services, as opposed to the number of persons receiving services in these settings. The cost of public psychiatric institutions continues to escalate despite declining population, threatening to overtake the basic trend in most States toward consistently increasing the proportion of funds spent on community programs. Contrary to the authors' contention, however, the National Plan reports that 73 percent of patient care episodes (1975) are on an outpatient, noninstitutional basis (Public Health Service 1980).

The "Total Institution": To Replicate or Not to Replicate?

In general, the concept of the "total institution" has significant heuristic value in explaining the real difficulties encountered in the process of deinstitutionalization. When one considers how public psychiatric hospitals met many of the basic living needs of patients, it should be remembered that many primary needs, such as those for autonomy and continuity of family and social relationships, were not well met, and that a major unanticipated consequence of almost total reliance on institutions is what has been referred to as "social breakdown syndrome," or "institutional dependency syndrome." The aim of an improved process of deinstitutionalization. The "Total Institution": To Replicate or Not to Replicate? In a discussion of whether and how to replicate some of these "total institution" functions in the community, it is essential to examine the full range of authorities and agencies which might each provide parts of the needed services array, as well as to propose mechanisms to coordinate such service delivery and assure its availability. Unfortunately, the narrow focus of Shadish and Bootzin's article on nursing homes seriously flaws the logic of the discussion. What the authors are essentially describing are the problems in making a transition from one institution to another. Far different and, in many cases, more serious problems have resulted from failure to change the manner and the structure through which these "total institution" functions are provided in the new community context. In other words, the critical issues involved in the systemic failure to develop a decentralized but reliable system of community support services in the community and the complex problems underlying this failure are largely ignored by the authors. Notwithstanding this neglect, the authors conclude with the assumption that constructing such an alternative system without an institution as its core is largely impossible.

The authors' discussion of problems involved in promoting "social integration" of discharged patients is a positive one and highlights a critical issue in developing community systems. It does, however, tend toward "blaming the victim" insofar as it ignores the important role of stigma and community rejection as a major impediment to social integration of ex-patients. Their discussion of the "custody" function of institutions, on the other hand, is unclear and, in general, poorly thought through. It would have been far more helpful had they distinguished among such critical elements of this concept as protection, stabilization, and shelter. These functions can be served in many different settings and through many different approaches. Staff of one statewide screening program found, for example, that simply by providing emergency housing they were able to cut their admission rate to the State hospital by one-third. Similarly, experiments with nonhospital crisis stabilization approaches, such as those using outreach teams or family foster homes, have been increasingly successful (Polak 1978). To fail to distinguish among various components of "custody" allows Shadish and Bootzin to build a stronger case for institutional alternatives than is warranted.

In raising the issue of "patient expectations," Shadish and Bootzin have identified another important area, but in general they fail to address the issue of the consumer's experience of the system in any meaningful way. Instead of focusing exclusively, for example, on how patients can subvert the system, it might have been more helpful to use an approach such as that used by Lamb (1979) in his study of board and care homes in California, in which ex-patients were asked directly about their experiences in various facilities.

The National Plan: An Alternative View of the "Nursing Home Problem"

Before the major proposals of the authors on the future role of
nursing homes in the mental health system are discussed, it might be helpful to review some of the findings and recommendations of the National Plan in this area. The National Plan describes some notable dimensions of the problem: the lack of mental health services staff in these settings, nursing home staffing patterns which are much lower than those in public psychiatric hospitals, the absence of standards to assure that the needs of mentally ill persons are being met, and the almost complete lack of research attention to this area.

In describing the issue of elderly mentally ill persons in certified nursing homes, the Plan distinguished among three aspects of the problem:

- Financing, regulatory, and legislative issues;
- Service delivery, including patient assessment, appropriateness of placement, and quality of care; and
- Human resources and training issues.

In the fiscal, regulatory and legislative areas, the Plan concludes:

In practice, regulatory interpretation of the law, eligibility and coverage requirements, absence of essential elements in the continuum of services, and economic pressure have led large numbers of patients to be placed in nursing homes inappropriately, and sometimes illegally. Reimbursement for services in these situations may serve to harm, rather than help, these people, and results in their being permanently institutionalized rather than being returned to independence.

Service delivery issues are critical. The Plan suggests the kinds of factors that should be assessed before the patient's placement in a nursing home:

Would the placement insure meeting the needs of the patient? Based upon the patient's level of functioning, is the nursing home appropriate?

Has the treatment and discharge planning process been an interdisciplinary approach? Are the goals well formulated?

Are the criteria for admission to the nursing home congruent with those that have been established by the treatment team for placement?

Does the nursing home have appropriate and sufficient, qualified staff to provide care, treatment, and rehabilitation?

Are the staff in the nursing home sufficiently trained in meeting the physical, psychosocial, and rehabilitation needs of the mental patient?

Is the patient's mental condition and drug regime sufficiently stabilized to warrant placement?

Has a physician been identified who will certify that the patient's needs will be met in the nursing home setting?

Have the hospital staff identified a "responsible party" for the patient prior to admission to the nursing home?

Will the nursing home administration be made aware of where emergency, psychiatric assistance can be obtained?

Has a financial plan been formulated prior to placement, which includes such factors as eligibility for Medicare/Medicaid, S.S.I., Social Security benefits, Veteran's benefits, Civil Service benefits, and name of conservatory?

Have recommendations been made to the nursing home administrator that patients placed in the nursing home setting should not have psychotropic drugs adjusted unless ordered by an outside psychiatric consultant? Dosage adjustment should not be made unless the patient is actually seen by the physician for assessment.

In the final area, human resources and training, the major current issues include:

limited attention to workforce planning, problems of recruitment in all categories, limited training for services to the mentally ill in nursing homes, geographical maldistribution, malutilization of personnel, inadequate supervision, and turnover of staff.

In its conclusions on improving the relationship between nursing homes and the mental health system, the National Plan makes recommendations in nine areas. First, in terms of Federal legislation and regulation, the emphasis is on developing a broad network of alternative community services outside of nursing homes, while at the same time improving mental health services within these facilities. Second, the importance of the State mental health authorities is emphasized. The Plan proposes an increased role in planning and coordination with other State agencies involved with nursing homes, monitoring the care of mentally ill persons there, providing consultation and technical assistance to the facilities, and facilitating training of nursing home providers. Third, the Plan calls for more research in social policy, clinical services delivery, and administration of services in nursing homes. Fourth, increased support of pre-service, graduate and continuing education training, as well as improved linkages between universities and nursing homes, are proposed. Fifth, specific steps need to be taken to define the place of nursing homes as one element in the mental health continuum of services. Sixth, fiscal and reimbursement policies which serve as disincentives to discharge
need to be modified, and a rehabilitation emphasis in these facilities needs to be introduced. Seventh, a variety of efforts in the area of prevention are proposed, including more effective programs to serve and divert prospective patients who might be inappropriately placed in nursing homes.

Eighth, the establishment of a national data base on mentally ill persons in nursing homes is called for, to include incidence and prevalence data, information on needs, and comparisons with other institutional and community-based subgroups. Ninth, steps to increase emphasis on advocacy and consumerism are proposed.

**Conclusion**

There appears to be a growing consensus that we have failed to incorporate nursing homes into the mental health system in any meaningful way. The National Plan cites some of the most negative consequences of this failure and proposes remedies. It is critical that we begin overcoming these problems through focusing on better linkages with nursing homes; it is equally important to proceed with great care in defining their role in an improved system.

A major weakness of the Shadish and Bootzin article is its suggestion that nursing homes are "one base on which an adequate system of mental health for chronically ill patients could be built" (p. 495). In fact, their harsh criticism of the inability of any community alternative to constitute such a base suggests that they are proposing nursing homes as the base for such a system.

To this reader, the basic logic of the article seems to be: there are many mentally ill people in nursing homes; nursing homes provide important asylum and treatment functions; at present, no one else can provide these functions; therefore nursing homes are an important basis for constructing a community mental health system. While the thrust of the argument that we need better mental health services within nursing homes is an important one, the contention that nursing homes, per se, with only moderate changes, should form such a critical basis of a mental health system is highly questionable. The same logic could be, and was, used to justify the dominance of other institutional settings in the past, and may, in fact, slow the development of community-based alternatives. Their approach largely ignores the massive problem of inappropriate placement in nursing homes and also overlooks the many experiments, and successes, in alternative community care approaches over the last two decades. It fails to take into account the important conceptual work done over the last few years in sharpening the definition of "intermediate care" as appropriate to the unique needs of chronically mentally ill persons, although such conceptual work is far from complete. Similarly, the article ignores the emerging emphasis on psychosocial rehabilitation.

In summary then, Shadish and Bootzin's article fails to address important systemic issues that are essential to understanding the role of nursing homes in deinstitutionalization. These include their economic role, the impact, often negative, of Federal attempts to assure quality of care in these facilities, and the basic disincentives within nursing homes to rehabilitation and discharge. Movement toward integrating nursing homes into the mental health service system, to be productive, must grapple with these difficult issues.

**References**


**The Author**

Paul J. Carling, Ph.D., is Deputy Commissioner, Vermont Department of Mental Health, Waterbury, VT. He was formerly Special Assistant to the Director for Mental Health Services, NIMH Office of Program Development and Analysis.