

DEINSTITUTIONALIZATION AND ITS EFFECTS ON THE ELDERLY:
INAPPROPRIATE PLACEMENT INTO LONG-TERM CARE

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ABSTRACT

The primary reason for electing to examine the inappropriate placement of the elderly into long-term care resulted from my ownership of a twelve-bed adult foster care home for the elderly in the small rural town of Sandusky, Michigan. In the five years that my wife Diana and I operated the home, we became aware that some of the elderly residents had been admitted appropriately, others should not have been placed in our facility, had an adequate community-based home care network been available and still others should have been placed in skilled nursing care environments. Additionally, some residents were transferred to nursing homes who should have remained at the adult foster care level. As I examined the materials used for this thesis, I discovered that the problem was much more severe than I had anticipated.

The inappropriate placement of the elderly into long-term care has puzzled policy makers and administrators since the days of the almshouses and public asylums. In the 1960's and 1970's, deinstitutionalization emerged as a matter of public policy and many elderly patients were returned to their homes in local communities without supports. Medical professionals, administrators of long-term care facilities, service providers and families often disagree regarding the needs of the elderly and have complicated the placement decisions for elders being placed into long-term care. These problems carry on into the 1990's.

Mental illness and economics are the two most evident factors that contribute to the inappropriate placement of the elderly into long term care. This paper provides potential answers to the problems presented and an avenue that may allow public administrators to become a part of the solution by playing a major role in the development of a national health care plan that will meet the needs of the elderly in this country.

DEINSTITUTIONALIZATION AND ITS EFFECTS ON THE ELDERLY: INAPPROPRIATE PLACEMENT INTO LONG-TERM CARE

I. INTRODUCTION: A BRIEF LOOK AT INSTITUTIONALIZATION OF THE ELDERLY

Deinstitutionalization had drastic effects on the elderly in the United States as long-term care became a multi-billion dollar service enterprise. It involves not only public sector government agencies at the federal, state and local levels, but the private for-profit and non-profit sectors as well. The definition of long-term care is "a range of services that addresses the health, personal care, and social needs of individuals who lack some capacity for self-care" (Kane and Kane, 1982). Thus, the long-term care product is the service provided to those suffering from chronic physical or mental illnesses, mental retardation, or other severe disabling conditions. It also includes the professional and paraprofessional jobs, research, and capital generated through the provision of long-term care. Long-term care is financed through both public and private sources. Long-term care seems to be a problem that has eluded any significant remedy, not only because of conflicting legislative authorities, providing different financing mechanisms, the fragmented organization and delivery of services, and the influence of organized interest groups on policy, but also because a comprehensive solution to long-term care has not been sought (Harrington, 1985).

The public policy debate has often framed the problem in the form of discrete issues arising from government crises in meeting the long-term care burden or in providing quality care with government financing services, provided largely by the for-profit sector. Long-term care became a public policy issue only after attention was called to the skyrocketing cost of

institutionalization of the very old and sick in nursing homes and the allegations and investigations of fraud, corruption, and even criminal abuse of patients. From a political perspective, long-term care did not evolve as a result of rational planning for the needs of America's older citizens. It evolved piecemeal and as a by-product of a health and social welfare system in crisis (Freeland and Schender, 1983).

Inappropriate placement of the elderly into long-term care has its roots as far back as the 19th century. The elderly had always been directed towards the almshouses throughout history as a shelter for those who were destitute in old age. The oldest and broken of the nation's largest cities were likely to spend their final days confined to the poorhouse. Philadelphia was one large city where, until the mid-19th century, individuals of advanced age constituted about one-fourth to one-third of the inmate population. A survey of the public asylums of Rhode Island revealed that 31% of all almshouse paupers were over the age of 60. These persons were generally institutionalized as an act of charity rather than as a punishment. They were viewed as too sick and weak to survive outside the asylum (Achenbaum, 1978).

The second half of the 19th century brought an increase in the proportion of old persons to the almshouses. By 1904, the national almshouse population was 160,000, and 69,106 of these or 43%, were over 60. The industrial states had larger increases in the number of elderly residents into the almshouses. The authors of the 1910, "Report of the Commission on Old Age Pensions, Annuities, and Insurances," presented their findings as conclusive proof that old age had become a serious social problem by reporting the following: "The strikingly high proportion of persons entering the pauper institutions late in life points to the close connection between old age and pauperism. It is clear that such pauperism is, in most cases, the result of the infirmity of advancing years rather than the misfortunes of earlier years" (Achenbaum, 1978).

The high rate of aged institutionalization resulted from changes in the treatment of middle-aged adults and children. Various reform societies had begun to free redeemable young paupers from the confines of the poorhouses. These organizations sent adolescents to the countryside to find work and a healthy environment, while other groups placed the needy in homogenous institutions far removed from the corrupt influence of the pauper asylum. They sent the young to homes for orphans, the insane to mental institutions, the deaf, dumb, and blind to schools for the handicapped, the able-bodied to houses of industry, and even the petty criminals to the reformatory and prison. These persons had traditionally filled the poorhouses. With their departure, the old and sick became increasingly visible as the asylum's most numerous inmates. Welfare administrators assumed that the cheapest means of supporting needy old age was also the best, and so this way of thinking translated rapidly into placing the old in the nearest and least expensive almshouse (Quadagno, 1982).

American history portrays the almshouse as playing two major functions: It had served as an asylum for the punishment of the vagrant and able-bodied, and a residence for the poverty-stricken and ailing. In the late 19th century, upon the removal of the "lazy and corrupt," the hospital-like atmosphere of the institution became dominant. The public institution now reflected the state of its predominantly aged inmates. When aged individuals were admitted, the superintendents of the poorhouses assumed that, along with food and shelter, they would also have to supply medical attention. There was, however, no clear line between elderly persons admitted because of sickness and disability, and those institutionalized simply for shelter. Residents seemed to move between medical and almshouse wards with some regularity. The amount of space, supplies, and personnel, as well as the old man's or woman's physical and mental state, contributed to his or her

placement. The attitude of the medical profession that concluded that all old persons would eventually become patients in need of constant medical attention, helped to justify the transformation of the almshouse. The managers of these public asylums had begun to portray their institutions as peaceful homes suited to the needs and ailments of their aged residents by the late 19th century (Haber, 1983).

State mental hospitals were beginning to be established with public funds in the late 18th and early 19th centuries. Dorothea Dix was responsible for the appearance of the state hospital issues on the national scene. Dorothea Dix almost singlehandedly exposed the conditions in county poorhouses and the like in the 1840's. She publicized the use of iron chains and shackles, and the foul atmosphere and inhumane conditions found in the facilities housing the mentally ill. She argued that local government could not care for those people and that the burden must be assumed by the state. Almost all of the northeastern and midwestern states supported her concept of the state-funded mental hospital by 1850, and by 1860, 28 out of 33 states had at least one public mental hospital (Greenblatt, 1971).

Moral treatment was at its height of popularity at this time and set the pattern for state hospitals to follow, by providing the humane, benign and warm family care model, proposed by its pioneers. However, the reverse happened. The facilities established, were designed to provide asylum and were located outside large populated centers. The isolation proved to be detrimental in the long run. The restrictions on mail, family visitation, and social contact with members of the patients' home communities, furthered the isolation, originally necessary to hasten recovery from the stresses of 19th century American life. Large physical plants were designed to provide bare patient care by permitting a diversity of medical services, more efficient organization, and better classification of patients. However, their huge size

destroyed the family quality sought by the original medical superintendents, and instead, imposed the impersonal and inhumane atmosphere that was a setback to moral treatment. The hospitals of this era were intended to employ more qualified physicians and be situated in more pleasant surroundings than the county poorhouses, and here too, they failed (Greenblatt, 1971).

The optimism about treating mental illness, which was invigorating at the beginning of the 19th century, had turned to pessimism by its end. The difficulties in translating moral treatment from the county poorhouses to the new state hospitals contributed to the disillusionment with moral treatment. The mentally ill did not receive prompt, effective treatment and were not returned to their homes, thus making the state hospital population rise. This necessitated the construction of more and more facilities to avoid overcrowding and disreputable conditions appearing. State hospitals were at an additional disadvantage. They were unable to choose whom to admit. Some of the more fortunate private facilities could turn away the "undesirables." Therefore, the institutions tended to receive the most difficult, violent, chronic patients, and the aged, with no hope of recovery. The state legislators' unwillingness to support these hospitals at the same per capita level of services, staffing, and conditions, inevitably lowered the quality of these hospitals. Overcrowding had become a major problem by the 1860's and 1870's, with no remedy in sight (Haber, 1983).

The controversy raging among asylum psychiatrists and between them and the new profession of neurology was yet another factor in the decline of psychiatric care. Weir Mitchell, the famed neurologist and psychiatrist, in 1894, launched a pointed attack on asylum psychiatrists, criticizing their isolation from the rest of medicine; their failure to support psychiatric research; their mishandling of mental patients and mismanagement of psychiatric institutions; and their lack of quality training programs and their complacency (Grob, 1983).

The press and court system began their attack on psychiatry. Scandals that were described by ex-patients of state hospitals were occurring in the mid-1800's as well as detailed "abuses, cruelties, persecutions, and unjustified commitments." These scandals fueled fires in the press and some charges were directed at the medical superintendents themselves, accusing them of moonlighting, living luxuriously, and running plantation-like facilities (Grob, 1983).

Clifford Beers came to the forefront at the start of the 20th century as a major psychiatric "lay" figure. The publication of his book, "Mind that Found Itself," in 1908, expressed his accounts of his hospitalization as a mental patient. Beers began a reform movement that revolutionized psychiatry in America. Beers and the committee stressed prevention through effective child-rearing practices and early detection of mental illness, both of which were institutionalized in the network of child guidance clinics that soon sprang up across America. The committee was effective not only in sensitizing the American public about the plight of the mentally ill, but also in stimulating research and training in psychiatry (Greenblatt, 1971).

Another development in the delivery of services away from the state hospital, in addition to the child guidance movement and primary prevention, was the establishment of a new psychiatric facility, "the psychopathic hospital," usually associated with a university or general hospital. These facilities were modeled on German institutions and stressed short-term observation, evaluation, and treatment for acute illness. They referred their moral chronic and intractable patients to "longer-stay" facilities such as state hospitals (Greenblatt, 1971).

World War I provided data, summarized and publicized by Thomas Salmon, previously the medical director of the National Committee for Mental Hygiene, that furthered the move away from institutions for the mentally ill. Salmon's

principles of proximity (treat them where they lie), immediacy (treat them quickly), and expectancy (expect prompt recovery), became the foundation for crisis intervention, elimination of waiting lists, and local decentralized outpatient clinics (Grob, 1983).

In the period between the World Wars, little occurred that directly affected the state hospital movement. The most influential development in American psychiatry was that of psychoanalysis, which had previously been isolated in small study-like societies but was beginning to be integrated into hospital psychiatry. The most prominent example of this was the Menninger Clinic in the 1930's. After the discovery of the spirochete in 1913, and the psychiatric sequelae of the influenza epidemic of 1917, there was heightened interest in the organic causes of mental illness. With development of the convulsive therapies in the mid- and late-1930's, state hospitals at last had a form of treatment that was easily administered, efficiently delivered, and markedly effective for certain diagnostic entities (Grob, 1983).

The important single development in the delivery of mental health services by state mental hospitals was that of deinstitutionalization. The mental health experts refer to deinstitutionalization as the trend to move the severely and chronically mentally ill from state hospitals to community settings. Deinstitutionalization had its roots in the early 60's and took effect in the late 60's and early 70's. Drugs that had been tested and accepted, permitted the suppression of mental disorders enabling state hospital residents to be treated as outpatients and returned to their communities. The Community Mental Health Centers (CMHC) Act passed in 1963 and developed local centers to provide the outpatient mental health services for those returned back to their communities. This paper will examine the reasons for deinstitutionalization and the manner in which it occurred (Talbot, 1978).

As the aged made up a good portion of the residents in these state hospitals, they too fell victim to the suffering of returning to their local communities and not finding the appropriate long-term care facilities and support systems. Instead, many of the elderly were being inappropriately placed into long-term care (Talbot, 1978).

II. THE BASES OF THE NATIONAL CONSENSUS THAT FORMED THE POLICIES TO IMPLEMENT DEINSTITUTIONALIZATION

A. SOCIAL, SCIENTIFIC, AND INTELLECTUAL DEVELOPMENTS THAT CONTRIBUTED TO THE RESHAPING OF THE NATIONAL MENTAL HEALTH SYSTEM.

The Second World War had a powerful influence in several areas at once. The war provided frightening evidence of the extent of mental illness in American society (Bluestone and Harrison, 1982). Approximately 12% of all men screened for induction into the armed forces, from 1942 to 1945, were rejected on neurological or psychiatric grounds, a number accounting for nearly 40% of all rejections. Close to 37% of all personnel leaving the Army, because of disability, had been men who had previously been judged fit to enter service but were eventually discharged due to neuropsychiatric problems. A loss of over 2,000,000 men due to neuropsychiatric disorders exceeded the total number of servicemen who were stationed in the Pacific during World War II. This discovery caused many in public and private life to recognize that psychiatric problems had weakened the American war effort and it also raised the uncomfortable issue of how many more civilians might be similarly disabled. This question certainly made people uncomfortable, because the pool of young men considered for military service was thought to represent the finest that America had to offer (Bluestone and Harrison, 1982).

The problem of psychiatric casualties among servicemen induced the military to experiment with new methods of psychiatric treatment, which led to major therapeutic advances. This was another sense in which wartime

experiences gave form to the post-war mental health system. Military psychiatrists demonstrated that early intensive treatment could result in high rates of recovery for even diagnosed psychotics. They also made greater use of sedation and hypnosis as therapeutic agents. The military psychiatrists directly witnessed certain social and environmental aspects of psychiatric disorder. They attempted to incorporate this insight into treatment such as group therapy (Estroff, 1981).

The existence of large numbers of psychiatrically disabled servicemen and veterans served to lessen the longstanding stigma associated with emotional breakdown. These men were injured in service to their country and the military captivated the eyes and ears of politicians for the sake of passing mental health legislation. After the war, high-level personnel in the Division of Mental Hygiene of the Public Health Service prepared legislation for America's first national mental health program, which Congress finally passed as the National Mental Health Act of 1946. While the Senate hearings on this bill were being conducted, a Marine captain described his recent psychiatric hospitalization and the dire need to expand the kinds of therapeutic efforts that had enabled his recovery. Offering the testimony on his own initiative, the young flier's words carried no self-pity, but an unquestionable sincerity of interest in the need for active treatment programs for the mentally ill. His statement moved his audience deeply (Estroff, 1981).

The Second World War went far in alerting Americans to the scope of the problems of mental illness and the values of new treatments. It was now evident that mental illness could afflict anyone and was not restricted to only the poor, ethnic minorities or social outcasts. The proof that situational factors could contribute to emotional breakdown could now be accepted by those who had to set policy (Bluestone and Harrison, 1982).

Before the passage of the National Mental Health Act, mental illness was considered to be a medical problem and left to state governments and the medical profession. World War II brought to light the growing number of individuals with emotional disorders and mental illness and became a focus and responsibility of the federal government (Bluestone and Harrison, 1982).

A quickly spreading critique of mental hospitals during the post-war years was another major influence on the mental health system. This critique by popular and scholarly writers began as a movement to discredit contemporary patterns of institutional care, although ended up contributing in its own way to a new understanding of the problem of mental illness. The movement originated during the war with the activities of conscientious objectors to work as attendants in mental hospitals. Upon arriving at their assignments, alternative service personnel found decrepit and substandard conditions, which many determined to reform. They prepared and distributed various forms of literature whose purpose was to identify the deficiencies of state institutions. When the war ended, the conscientious objectors founded the National Mental Health Foundation to help enlighten society to the true nature of mental illness and deficiency; to cooperate with others in the promotion of mental health and the prevention of mental illness; and to seek higher standards of care and treatment in mental institutions (Rothman, 1971).

In the 1950's, two kinds of critiques emerged, regarding mental hospitals. National periodicals constituted the primary front of a journalistic campaign against state facilities for the mentally ill. Life magazine published "Bedlam USA" and "The Shame of our Mental Hospitals" appeared in the pages of Reader's Digest in 1946. Several major newspapers such as the Cleveland Daily Press, Chicago Daily News, San Francisco News, and St. Paul Dispatch assigned reporters to regulate coverage of local state hospitals. Book-length journalistic treatments were other forms of popular

exposes such as The Shame of the States in 1948 by Albert Deutsch and John Martin's The Pane of Glass in 1956. Mary Jane Ward's memoirs composed The Snake Pit in 1946. Ken Kessey's novel, One flew over the Cuckoo's Nest, which enjoyed great success with readers and movie-goers in the late 1970's, actually belongs to this earlier era, having first been published in the early 1960's (Lamb, 1979).

The other form of critique was social-scientific, and focused characteristically on the consequences of the structure, functions, professional composition and relationships, or institutional environment of a particular facility for individual patients (Lamb, 1979). Psychiatrists, anthropologists, and sociologists were involved as researchers who produced such titles as The Mental Hospital (1956), The Psychiatric Hospital as a Small Society (1958), and Asylums (1961), (Lamb, 1979). These hospital exposes and studies did much more than simply elaborate a critique of existing institutional arrangements for the care of the mentally ill. They also helped to alter the image of the care of the mentally ill by identifying yet another external cause of this disability, which was the hospital itself. Popular and scholarly writers arrived at the same ironic conclusion, and that was that mental hospitals as currently organized, were making worse the very problem they were trying to remedy (Lamb, 1979).

The discovery of tranquilizing drugs and their use in the treatment of patients was yet another main reason used for deinstitutionalization of the mentally ill. The two drugs that first gained the attention of the scientific community were Reserpine and Chlorpromazine. These drugs were both developed by researchers in India and France, and viewed with great suspicion by American physicians and hospital administrators. Both drugs eventually won wide acceptance as valuable agents for the reduction of anxiety and other psychiatric symptoms without making the patient unconscious (Maluccio, 1980).

Reserpine and Chlorpromazine proved especially useful to the many mental health professionals who, by the end of the 1950's, were working to define a new, more delimited role for the state hospitals. These drugs eliminated much of the need to use physical restraints. Tranquilizing drugs contributed to a positive atmosphere between staff and patients that greatly aided such new rehabilitative efforts as milieu therapy, which attempted to match the approach of the clinical personnel and the program of therapeutic activities to the problems of the individual patient. Within a short time, early discharge programs became common and the inpatient public mental hospitals incurred their first sustained decline in American history (Maluccio, 1980).

Tranquilizing drugs affected the climate of opinion in mental health care in a way that carried beyond their definitively proven value as medical applications. These drugs kindled an aspiration of hope in the care of the chronically mentally ill. The development of these drugs seemed to strengthen the sometimes tenuous link between psychiatry and physical medicine. This was to the benefit of the images of mental health professionals and the mentally ill. Analysts have claimed that it "promoted psychiatrists to physicians in the eyes of many members of the public." This would now allow the public to accept mentally ill patients into their community, although in a very structured manner (Maluccio, 1980).

B. A LEGISLATIVE HISTORY OF DEINSTITUTIONALIZATION

In the early 1950's, medical-clinical models surfaced with major developments in somatic therapies. Tranquilizing phenothiazines, anti-anxiety drugs, and anti-depressants permitted the suppression of crippling behaviors enabling thousands of "incurable" patients to be treated as outpatients. Even pre-frontal lobotomies and electroshock provided a note of hope and spurred the search for more sophisticated means of treatment. Although the medical-

clinical models of psychiatric care slowly lost ground, the social psychiatric model, in particular, which emphasized prevention and environmental or interpersonal causes, began to supersede them as the basis for public mental health work. The macroscopic social psychiatric view now took social pressures into account, whereas the medical-clinical models would trace mental disturbances to internal causes (Axinn and Levin, 1975).

The government now worried about public costs and exposes, although the practitioners using the social psychiatric model were realizing that mental health hospitals were worse than medical-clinical models would have indicated. The general rejection from the lack of attention by the staff and enforced passivity desocialized patients and stripped them of individuality. Due to general lack of psychotherapy, the model also seemed a dead-end one. In place of the defacto "custodial model," social psychiatry advanced the "therapeutic community" model which was based primarily on the pioneering work of Maxwell Jones of England.

This proposed to make the mental hospital a therapeutic milieu, which included all on-going activities. The patients now had as much responsibility as possible in their own affairs and those of their wards. Hospitalization was a last resort, and patients were returned to the community as quickly as possible. Studies quickly demonstrated the model's effectiveness (Axinn, and Levin, 1975).

The use and interest of the therapeutic community model increased further exploration into the emphasis of aftercare and consequently, outpatient clinics. The first outpatient clinic in the United States was founded in 1885 and the Commonwealth fund established model clinics nationwide in the 1920's. There were fewer than 400 outpatient clinics in the United States by the beginning of World War II. After the war, with National Institute of Mental Health (NIMH) and Veterans Administration (VA) funds available, outpatient

clinics sprang up and flourished. This method of delivery constituted a common ground between different modes of therapy and in 1954, the number of clinics had more than tripled to 1,234 (Guyther, 1986). Outpatient clinics were valuable, but they were not the solution because of the widespread variation in clinical quality, availability and type. Clients were often frustrated by long waiting lists or cumbersome referral procedures; by income-level cutoff, that deprived many people in need of free psychiatric care; and occasionally, by emphasis on research at the expense of client's needs (Brown, 1979A).

These inequities served to emphasize the lack of a coherent mental health plan. The mental health professionals were alert to the need for better mental health care. A 1955 Health Study Act (PL 84-182) authorized \$750,000 for a three-year study of the entire mental health field. The Joint Commission on Mental Illness and Health (JCMIH) sponsored in-depth research on every aspect of mental health and summarized in its final report, "Action for Mental Health:"

A fundamental pattern of social rejection that is nowhere better evidenced than by the continued existence of these "Hospitals" that seem to have no defenders but endure despite all attacks." (Leighton, 1982).

The JCMIH proposed a nationwide expansion and modification of mental health services. Though none of the programs it mentioned or recommended were new, the shift of emphasis was significant and mental health was now seen as a national problem requiring national coordination and funding. However, action for mental health remained a paper program only. The JCMIH came into being largely through initiatives of NIMH and the American Psychiatric Association. The final JCMIH recommendations were conservative and emphasized research. They were an extension and expansion moving towards long-term, basic research, as opposed to the NIMH, short-term applied research. A broad base therapeutic

philosophy was favored because of the absence of more specific and definitive scientific evidence on the causes of mental illness. JCMIH saw the psychiatrist directing other mental health professionals and performing the most difficult therapies. The report advocated the use of a "community mental health clinic," although they were seen primarily as the outpatient departments of general or mental hospitals. The hospital remained the focus of JCMIH's mental health system. The report called for more small mental hospitals and for the conversion of existing large mental hospitals into chronic disease treatment centers, emergency care, increased partial hospitalization, and more aftercare services. The JCMIH report edged toward social psychiatry in its move to community treatment, yet remained rooted in the conventional medical-clinical, hospital-based tradition of mental health. David Mechanic notes the following:

Action for Mental Health was largely an ideological document, and like poetry, it was sufficiently ambiguous to allow various interest groups to read into it what they wished. It is, therefore, not surprising that a vigorous political battle resulted at the federal level between those psychiatrists with a public health viewpoint, who wished to develop completely new precedents for mental patient care, and those psychiatrists more within the traditional medical model, who felt that considerable federal assistance should be invested in improving the quality of mental hospitals and their capacities to provide adequate treatment to patients. Those who favored a more radical break...were more influential with President Kennedy, and the final decision was to give greatest impetus to the community mental health centers...(Leighton, 1982).

President Kennedy formed a high-level committee to analyze "Action for Mental Health," which was the report that JCMIH had composed. The President presented the results in his February 5, 1963 message to Congress on Mental Illness and Mental Retardation. Kennedy ignored the JCMIH's mental hospital recommendations and called for federal funding to support construction and initial staffing of community mental health centers. His intentions were to replace the mental hospital system and to provide mental health care for all. The Senate held its first hearings in the Committee on Labor and Public

Welfare (LPW), chaired by the powerful Lister Hill (D-Ala.). The Senate hearings were friendly, although the House Committee on Interstate and Foreign Commerce (IFC) was tougher. NIMH provided information that estimated that a single Community Mental Health Center (CMHC) would cost approximately \$1.3 million to construct and that 422 CMHC's were contemplated, each with a staff of approximately 108 and each to cost over \$1 million yearly to operate. The American Medical Association (AMA) opposed the centers because of the fear of federal control of the health care system through regulations governing the use of staffing funds, although the AMA's Council on Mental Health endorsed federal support for staffing (Axinn, 1975).

The Senate version of the Community Mental Health Centers Act (S. 1576) passed 72-1. The House deleted the staffing allocations in a conference committee and the bill (P.L. 88-164) passed the House 414-0 on October 31, 1963, authorizing \$140 million for CMHC construction for fiscal years (FYs) 1965-67. The NIMH regulations implementing P.L. 88-164 required each state to formulate a plan for adequate mental care services. A state would be divided into "catchment areas" of 75,000 to 200,000 persons for each CMHC and to rank these in order of need for a CMHC. Each CMHC was expected to provide below cost or without charge, a reasonable volume of services to persons unable to pay (Axinn, 1975).

President Johnson noted in 1965, when he addressed the Congress, that communities with the greatest need hesitate to build centers without being able to identify the source of operating funds. He also reintroduced the subject of federal support for initial CMHC staffing in the same message where he proposed Medicare. A total of \$73.5 million was authorized for grants for over a three-year period, and any new service of a CMHC could receive sliding-scale initial staffing grants for the first 51 months of its operation (Rocheffort, 1984). In 1968, President Johnson set up the Bureau of Narcotics

and Dangerous Drugs to combat the soft and hard drugs that spread into the middle- and upper-class families which at that time had attracted national attention. While testifying before Senator Thomas Dodd's subcommittee on Juvenile Delinquency, Dr. Stanley Yolles, then director of NIMH, called for a social psychiatric approach to drug abuse, dealing with "alienation" and not just with drug addiction per se. This specialized problem, along with alcoholism, was assigned to CMCH's in the Alcoholic and Narcotic Rehabilitation Amendments of 1968 (P.L. 90-574). This bill authorized \$30 million for FYs 1969-70 plus continuation grants for the construction and staffing of specialized facilities for prevention and treatment of alcoholism and narcotic addiction. This authorization also provided alternative sources of funds at a time when Johnson, faced with a Vietnam strained economy, had begun cutting back on his Great Society programs (Jones, 1972).

Congress renewed and expanded the CMHC's purpose and appropriations in the early 1970's, but the Nixon administration still classified CMHC as a pilot program. The Nixon Administration was always antagonistic towards the social psychiatric approach of NIMH and clashed with Congress over the CMHC budget. While the 1970 Amendments were still before Congress, the Bureau of the Budget's recommendations for FY '71 showed a drop in real dollars for mental health administration, while medical manpower and materials and maternal and child health funds increased by 25 percent (Rocheffort, 1984). Signals in the press indicated a serious conflict between NIMH and the Administration which culminated with the departure of Dr. Yolles who said that he had quit, although HEW Secretary Robert Finch stated that he had fired him. Dr. Yolles parted by charging the Nixon Administration with the following words:

Abandonment of the mentally ill...lack of commitment to supporting mental health services for children...(I) differed from this Administration...(on) the encroachment of the Department of Justice as the final authority in medical determinations...(and) the introduction of partisan, political considerations in the appointment of individuals to scientific positions within the federal government" (Jones, 1972).

Congress, meanwhile, amended and in October, ratified the Comprehensive Drug Abuse Prevention and Control Act of 1970 (P.L. 91-513). The Act authorized \$180 million for FYs 1971-73 for drug abuse education and treatment, and narcotic addiction treatment. This allocation was twice the amount actually used in staffing grants between 1965-69 (Jones, 1972).

The first drastic moves after the 1972 elections were that Nixon declared HEW and other agencies "too fat, too bloated" and vowed to "shuck off" wasteful 1960's programs. The House fired back in hearings on the Health Programs Extension Act of 1973. These hearings allowed a direct challenge to Nixon's claim that the time had come to turn the CMHC program over to the states. Nixon's key contention was that state, local and insurance payments could adequately fund CMHC's. A series of witnesses testified that only 12% of CMHC income came from private and public insurance programs and that state and local governments were unlikely to expand CMHC support. The possibility of using federal revenue-sharing money, a Nixon philosophy, was slim indeed. Continued federal support was a necessity at this point, for the survival of all but the most affluent of CMHC's (Brown, 1979).

The Office of Management and Budget claimed that the CMHC's placed little emphasis on treating the poor, although HEW statistics showed that 42% of the clients served by CMHC's had family incomes lower than \$3,000 per year, 64% lower than \$5,000 per year. The Extension Act (P.L. 93-45), continuing such popular programs as the Hill-Burton Hospital construction, migrant health plan, and CMHC program, passed the Senate 94-0 and the House 371-1. While publicly compromising in signing PL 93-45, Nixon was attempting to use his administrative powers to slash mental health programs. Nixon dismembered the

Health Services and Mental Health Administration before signing PL 39-45 and divided its functions between the new Health Services Administration and Health Resources Administration. NIMH was downgraded to its pre-1967 position within the National Institutes of Health and its personnel and training budget was cut from \$97 million in FY 1972 to an expected \$60 million in FY 1975. Nixon also had impounded \$52 million in CMHC grant funds, but on August 3, Judge Gerhard Gesell ordered their immediate release. A coalition of organizations and state governments successfully sued HEW for the release of \$126 million in alcoholism treatment and mental health training funds impounded for FY 1973. Nixon's attempts to control or shrink the CMHC program did not succeed (Brown, 1979B).

Congressional attention was diverted from CMHC's due to Watergate. House hearings in early 1974 aired a Government Accounting Office report indicating the probable crippling of the CMHC program without continued federal assistance and the need for CMHC administrative changes, although no action was taken. The long-delayed Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments (PL 93-282) did finally clear Congress. This legislation created the Alcohol, Drug Abuse, and Mental Health Administration within HEW to oversee the agencies created by the breakup of the Health Services and Mental Health Administration, effectively counteracting Nixon's administrative shuffle. After Nixon's resignation, the House and Senate began to examine the CMHC program in detail and hearings showed that, although generally a success, the CMHC program required administrative and regulatory overhaul (Bell, 1980).

Title II of PL 94-163 completely rewrote the Community Mental Health Centers Act. The Act included the following:

1. It explicitly retained the original five essential services.
2. Significantly expanded consultation and education.

3. Required special services for children and the elderly.
4. Made alcoholism and drug abuse programs optional at the HEW Secretary's discretion.
5. Community control was mandated by keeping health care providers in the minority in representative governing bodies of individual CMHC's.
6. Ongoing quality assurance programs were required.
7. A new grant category was added, including financial distress grants to centers whose original grants had terminated (Brown, 1979A).

Before the passage of the Community Mental Health Centers Act, the mental health care system was dominated by hospitals and characterized by gross inequities in the quality of life and availability of non-hospital care. President Kennedy's "bold step forward" in the mental health care arena, had two overriding goals which would supplement, surpass, and eventually replace the mental hospital system of care and establish a new system of community care that would provide mental health services to all in need. After years of pessimism, the mental health movement was shaken to action by this opportunity to create a "third revolution" in psychiatric care, although the CMHC program had failed to realize its mandates and was fraught with built-in contradictions and weaknesses (RocheFort, 1984).

III. THE ELDERLY AND DEINSTITUTIONALIZATION

Deinstitutionalization returned elderly persons that were at risk, to their local communities. The elderly were vulnerable, frail, impaired, disabled, anti-social, and hard to manage. These persons had multiple problems; physical, psychological, economic, social, environmental, and familial. These problems were generally overlapping and interrelated. They were incapacitated and had a combination of physical and other problems. These older persons were often socially disadvantaged perhaps even socially isolated. While many of these persons may have been loners all their lives, others may have become isolated by their circumstances in later life. Alcohol

and/or drug abuse may have been part of their constellation of problems. It was not uncommon for them to be at risk for suicide (Aronson, Bennit and Gurland, 1983).

Many of these elderly persons in need of services were and are resistant to accepting help and hostile to those offering assistance. If they do not agree to accept services, they may be difficult to help because of their multifaceted problems. These elderly may receive sporadic fragmented care by multiple agencies or may manage to slip through the cracks and receive no care at all. They may be a source of frustration to helping professionals for many reasons and are, in general, a challenge to the service system (Aronson, Bennit and Gurland, 1983).

The elderly with mental illness problems challenged and continue to challenge several basic assumptions of professionals. It is generally assumed that people will seek help in times of need. These elderly persons, however, may fade into the background just when their need is the greatest. Professionals assume that they will be able to perform some positive interventions, but these clients may not perceive these services as helpful and may, at times, actually run away (Aronson, Bennit and Gurland, 1983).

A 68 year-old man, lived in an abandoned building with no electricity or heat. He was brought to the attention of an outreach program whose case worker visited him at home. The case worker was appalled by the lack of basic amenities. A plan was developed to try to get him badly needed medical treatment and expedite placement in public housing. He managed to be away when the case worker came back to visit to solidify the plans they had discussed and systematically managed to avoid several subsequent attempts to meet with him again (Jacobs, 1980).

The mentally frail elderly do indeed have needs which may at times be of an apparent emergency nature. These needs are often quite concrete in nature (housing, food, clothing, money, medical care) and may necessitate pragmatic interventions rather than employment of traditional "therapeutic" modalities. Some professionals may tend to shun these patients because they need only

these concrete things. Some programs may be based on a medical rather than a social model and may not recognize these persons as appropriate clients at all.

A 90 year-old client of a community mental health center outreach program was found to have no food in her refrigerator when her therapist made a home visit. The therapeutic intervention that day consisted of marketing by the social workers who made the home visit. Certain programs might not accept this type of client or might terminate her after an initial evaluation (National Institute of Mental Health, 1979).

If the agency does not reject the client, the client may reject the agency. There may be resistance or frank opposition to accepting services on the part of these elderly persons in the face of what appears to be overwhelming, even life-threatening, need.

A street person comes in the emergency room with a gangrenous limb. When told he will require admission, he decides to leave and return to the street (Jacobs, 1980).

The needs of the mentally ill, frail elderly are complex and often cross disciplinary lines, requiring a series of interventions by a diverse group of professionals and paraprofessionals from various agencies and services. Another common assumption is the desirability of development of rapport and regular contacts. While on-going services may seem appropriate, these persons may accept only sporadic intervention in times of crisis. The existence of informal support to help persons survive is another common assumption and for many of these elderly, natural support networks, may be almost non-existent. Families may be estranged, difficult to enlist, and even hostile. The following case may illustrate the above mentioned.

A 70 year-old retired sailor had nursed his wife through a long terminal illness. For a while after her death he had apparently functioned quite well; however, he gradually became withdrawn and estranged from his family, friends, and neighbors. Ultimately he became reclusive, and his relationship with his sons deteriorated to the point that his sons merely dropped food in the kitchen of his apartment. He refused to even leave the bedroom to acknowledge their visits. The sons began to worry and eventually contacted a senior citizen's mental health program. When a home visit was made, a diminutive, poorly nourished, frightened man with a knee-length beard and similarly long hair peered cautiously out the bedroom door. He had to be approached gently and cautiously coaxed out of the bedroom. The sons had to be counseled and supported regarding initiating psychiatric intervention for their father (National Institute of Mental Health, 1979).

This 70 year-old man was taken to be treated; however, estranged families may actually prevent or sabotage any treatment for their impaired older member such as in the following case:

A moderately demented 75 year-old women residing in an apartment, where, due to clutter, she essentially lived on a couch in the entry hall. She had a part-time homemaker and was receiving some meals on wheels from a neighborhood agency as well. A home visit by a mental health outreach team for assessment of her apparently impaired health was requested by the meals on wheels agency. Her legs were seriously infected to the point of having maggots, and immediate medical treatment was advised. She refused to consent to treatment. The only remaining kin, a niece, not only refused to attempt to enlist her aunt's cooperation in obtaining treatment, but also was suspicious of the outreach team and requested that it refrain from providing any services until she called back which she never did (National Institute of Mental Health, 1979).

Professionals may experience fear or frustration because the mentally frail elderly are not easy people to deal with. Their problems are complex and often defy solution. For example, suicide is a particularly difficult problem for professionals in attempting to assist the elderly. This is a population that is at risk for suicide. There is invariably difficulty in assessing the severity of the potential risk. Once an assessment is made, there is often what is perceived as inappropriate medical backup or no backup at all. The emotionality of suicide threats sometimes makes it hard for the line worker to accept the decisions of supervising staff. Indeed a client's fear and pain are often shared by the professionals who try to serve them (Aronson, Bennit and Gurland, 1983).

Not only is the mentally frail person a challenge to the professional and the agency, but also to the long-term care system as it exists today. This group or set of groups impact on the various service settings that are components of the existing continuum of care for the older person, e.g., the adult home, the nursing home, the acute hospital, the senior center, the home care project, the protective services agency and the family. The impact of the "hard-to-manage" elderly on the senior center was explored previously in a study conducted by the National Council on the Aging (1979). Center personnel

are often on the front lines in serving this population. Many of these staff feel ill-equipped to deal with this group in senior centers as their programs do not contain psychiatric components and these clients are stigmatized. Likewise, home care personnel do not have needed psychiatric resources available (Kay and Bergman, 1980).

The mentally ill elderly also frustrate institutional personnel as well. The multiplicity of problems often defy classification into the current levels of institutional care available. The older person with early dementia, for example, may be too physically intact to qualify for skilled nursing care, yet too mentally impaired to be placed in a less supervised setting, such as a health-related or intermediate care facility, where he/she is required to function with some independence in the basic activities of daily living. Even if he/she is accepted into an intermediate care facility, he/she may not be suitable for that setting and may require a spectrum of added services just to maintain his/her limited level of functioning within the institution. There is no third-party reimbursement for these added services, and they, therefore, usually are not available (Kay and Bergman, 1980).

Ninety-five percent of the elderly reside in the community on a given day. Thus, despite prevailing stereotypes, only 5% of older persons are institutionalized at any given time. Institutions that are included in these statistics include long-term mental hospital units, nursing homes, and veteran hospital long-stay wards. The number of persons that fall into the category of mentally frail elderly, is almost impossible to determine. It is reported that at least 60% of all nursing home residents carry some diagnosis of mental impairment (Aronson, Benit and Gurland, 1983). Adult homes and other similar domiciliary care facilities are not considered in the statistical data regarding elderly institutions, despite the fact that facilities are home to

a large number of older persons. For every nursing home resident with a functional impairment, there are between one and 2.5 persons of similar impairment who are residing outside of institutions (Kartman, 1979).

Care for elderly in nursing homes has come to replace a substantial portion of care that had been delivered in mental hospitals. It is evident that a substantial portion of increased nursing home utilization from 1960 to 1970, stems from the fact that nursing home care has come to replace much care that had been provided in other long-term care settings. Nursing homes in this country have been the central, long-term care setting for the nation's impaired elderly (Burton, 1979). The proportion of elderly, from 1960 to 1970, residing in nursing homes, increased by 69 percent and the use of mental hospitals by the elderly, actually declined by 48 percent. The use of all institutions by the elderly increased by 30 percent over the decade. Figures show that within the group of all institutionalized elderly persons, the percentage in nursing homes rose from 63 to 82 percent.

Between 1960 and 1970 the proportion of elderly persons in nursing homes (including personal care homes and homes for the aged) increased 69 percent, from 2.34 to 3.96 persons per 100 elderly population. The types of institutions that were utilized at this time included the following: nursing homes, personal care homes, homes for the aged, mental hospitals, correctional institutions, TB hospitals, chronic-disease hospitals, and others (Burton, 1979).

The deinstitutionalization movement has been around for a number of years. Attention presently is focused on deinstitutionalization of the mentally retarded and other developmentally disabled. It began, however, with public mental institutions. Deinstitutionalization can take one of two principle forms: the diverting to other settings at the intake or screening point of individuals who formerly would have been admitted to mental

hospitals; and secondly, the placement of patients already in mental hospitals back into community settings. In most states, the former process appears to have preceded the latter. The community Mental Health Center legislation passed during the early years of the Kennedy Administration, comprised an initial impetus in some states and a further encouragement in others (Maynard, 1975).

The three principal explanations for the popularity of the deinstitutionalization concept for the elderly, appeared to be first, that care in a more natural or normal environment was more beneficial to the client; secondly, that the use of psychotropic drugs made care in intensive environments less necessary for some individuals, and thirdly, that a substantial number of elderly inmates did not really need to be in a mental institution but were placed there because there was no other setting in which they could be kept, totally at public expense. Public mental hospitals had become a readily accessible means of caring for impaired old people, especially if they demonstrated any symptoms of senility (Maynard, 1975).

These concerns of practitioners and reformers which eventually became manifest in federal efforts to encourage states to make greater use of community mental health centers and other community alternatives, came to square very well with the fiscal interest of state executives and legislators. They soon came to see, especially with the passage of Medicaid and then the Supplemental Security Income Program (SSI), that if their patients were placed in privately operated community facilities rather than in the state and county mental hospitals, the federal government would pick up a substantial share of the care costs, which would be lower per diem than the costs of care in state hospitals. In general, old age assistance and Medicaid discouraged the provision of care to persons in public institutions. Medicaid did permit reimbursement to public mental health hospitals if they could

qualify for accreditation by the Joint Commission on the Accreditation of Hospitals and if the state could demonstrate that it had plans underway to develop alternatives to use of state hospitals for the elderly (Dear and Wolch, 1987).

With the combination of all these forces, it is not difficult to understand the momentum that the deinstitutionalization movement acquired during the period from 1964 to 1970 in the proportion of elderly residing in mental institutions. Taking into account the above mentioned figures, it was estimated that the diverting to nursing homes of elderly persons who formerly would have gone into mental hospitals could account for up to 32 percent of the growth in nursing home utilization between 1960 and 1970 (Burton).

All of this indicates that the nursing home clearly was the primary long-term care setting by 1960, but that its dominance had increased immensely by 1970. A significant part of that increased dominance stemmed from increased substitution for care of the aged in mental institutions (Burton, 1979).

IV. INAPPROPRIATE PLACEMENT OF THE ELDERLY INTO LONG-TERM CARE

There is a great health care problem which exists in this country, a problem which both Congress and the current administration have not acted upon. That is, the need for a comprehensive community-based non-institutional long-term care system for the elderly. This need, which has long plagued this country, has been ignored both because of its complexity and cost and currently; this issue remains unresolved (Packwood, 1980).

While Medicaid and Medicare are the major funding sources of long-term care services for the elderly, the separate rules, regulations and eligibility criteria governing such programs continue to encourage institutionalization,

inappropriate types of placement and care, and in some cases, services not reaching those in need. Since institutional care financing is emphasized and comprehensive community health care options are not generally available, the present health care system fosters increased reliance upon institutional care (Kane and Kane, 1980).

Historically long-term care services have been delivered through institutional settings, regardless of the level of skilled care involved. As a result, older persons would frequently be placed in chronic care hospitals or nursing homes. Long-term health care services should concentrate on, encourage and emphasize the continual functional independence of an individual and his/her ability to function with existing impairments and disabilities. Such services are, in part, designed to prevent premature and unnecessary placement in a nursing home. Elderly people often are institutionalized because the non-institutional services that they need do not exist, and because their economic and social situation is such that they cannot afford to remain in their own home and not necessarily because they require such care. This problem is compounded by the institutional design of the current system. Once an individual reaches age 65, his/her chance is one in four of entering a nursing home. This chance increases to one-in-two when an individual reaches age 85 (Packwood, 1980).

While it is understood that both Medicare and Medicaid programs have a definite bias towards placing an individual in a hospital or nursing home, Medicare offers only one program to assist seniors and persons with disabilities to avoid premature and inappropriate placement in a nursing home. Yet, the eligibility for this program contains restrictions that force people into hospitals before they can qualify for home health care (Kane and Kane, 1980).

During the period of 1967-1977, the number of nursing recipients has more than doubled and while in 1964, 14.7 percent of persons age 85 and over were in nursing homes, in 1974, 25.3 percent of the 85 and over population were in nursing homes. This problem is compounded by the fact that an estimated 10-25 percent of nursing home residents do not require the level of care provided and are considered inappropriately placed, but cannot re-enter the community for one reason or another. These elderly that are institutionalized, will become increasingly less capable to care for themselves, the longer they remain in a nursing home (Packwood, 1980).

The basic issue facing government today is how to provide or pay for quality care at an affordable price. It is recognized that institutionalization of the elderly is essential for some, but inappropriate for others. Documentation is available to show that deterioration of a patient's condition can be linked directly to institutionalization and prolonged bed rest (Abdellah, 1978).

Of the one million elderly persons in long-term care facilities, 17 to 25 percent are placed there because there are no alternative care services available to them, thereby considered inappropriately placed. The Department of Health, Education and Welfare took on a major effort to include home health and social services as part of a broad cost containment effort to prevent inappropriate institutionalization. Institutionalization is appropriate when medical or physical needs are so great that provisions of services throughout a 24 hour period are essential. Around the clock nursing care of patients with myocardial infraction and cerebrovascular disease at the onset of illness, is an example of such a service (Abdellah, 1978).

A national study of skilled nursing facilities conducted by Public Health Services Office of Nursing Home Affairs in 1974, showed that approximately one-third of the patients were inappropriately placed. Documentation was also

provided to show that deterioration of patients' conditions can be linked directly to institutionalization and prolonged bed rest. Home health agencies are being considered a major alternative to institutionalization. Emphasis will be placed upon providing preventive and maintenance services. Many older and disabled people need a minimum of support services to allow them to remain within their own homes. Of the one million elderly persons in long-term care facilities in the year 1978, 17 to 25 percent were placed there because there are no alternative care sources available to them. This situation has not changed dramatically to present times (Kane and Kane, 1980).

On January 4, 1978, Representative Claude Pepper (D. Fla.), Chairman of the House Committee on Aging, released a General Accounting Office (GAO) report documenting the advantages of expanding home health benefits for the elderly. Congressman Pepper stated that,

"The (GAO) study underscored my long-held contention that the government has adopted a costly, counter productive institutional bias toward the nation's elderly citizens who need health care...It is tragic that home health care is considered the alternative to institutionalization...This institutional bias is both callous and costly." The GAO report concluded: "Until older people become greatly or extremely impaired, the cost of nursing home care exceeds the cost of home care including the value of the general support services provided by family and friends (Abdellah, 1978).

A more up to date look at the inappropriate placement of the elderly into long-term care is investigated by Richard Cairl, Ph.D.; coordinator for Research at Suncoast Gerontology Center in 1984. He designed a model project to prevent inappropriate institutionalization. Dr. Cairl comprehensively delineates the positive and negative outcomes of the project by stating that the model project is actually a pre-nursing home assessment system designed to screen out elderly who may be inappropriately recommended for nursing home placement. These patients, who can still function in an independent environment if receiving appropriate support, are recommended for community care services at a lower cost (Pfeiffer, 1984).

Dr. Cairl reports that the project has been successful but that there are several complex system problems which reduce the effectiveness of the program. Several policy issues are specified which relate to the interaction of ideal components of a pre-nursing home assessment model and modification of the long-term care system toward a more correct response to the needs of the elderly person. Dr. Cairl explores several identifiable imperatives which provide a context for the emergent theme of pre-nursing home assessment and long-term care:

- A. Demographic
- B. Fiscal Imperative
- C. Humane Imperative
- D. Increased Recognition of the Cultural Bias Towards Institutionalization and Inappropriate or Unnecessary Nursing Home Placements (Pfeiffer, 1984).

Among these imperatives, the demographic, fiscal and human or humane imperatives tend to be the most frequently cited. There is, of course, the fourth imperative which has generated considerable attention. This imperative centers upon the recognized bias in our culture towards institutionalization and the proportion of inappropriate or unnecessary nursing home placements which result (Pfeiffer, 1984).

Recent evidence indicates that between 10 and 20 percent of patients in skilled nursing facilities do not need the level of care provided and, as many as 40 percent of patients in intermediate care facilities are inappropriately placed and could function in some form of sheltered housing or in their own homes. These inappropriate placements carry heavy social and economic costs. Given the scarce commodity of an empty nursing home bed in many parts of the country, the inappropriately placed client becomes a liability. Moreover, such inappropriate placement subjects the individual to the discomforts, dependency, and regimentation which tends to characterize large and predominantly custodial types of institutions (Pfeiffer, 1984).

Many elderly persons are destined to remain in inappropriate settings for the remainder of their lives due to the lack of recognition and intervention of the relocation phenomenon. The potential for adjustment is considered limited to an older person because the individual is more dependent upon his immediate environment and often associates relocation with the loss of independence, rejection by family, and a prelude to death (Labouvie, 1973).

Studies on elderly persons transferred to different environments, have shown substantial increases in mortality rates and physical and mental deterioration (Killian, 1970). On the other hand, it has been demonstrated that with adequate preparation and services, most individuals can be safely relocated (Langer & Rodin, 1976).

A study conducted by the Erie County, NY Office for the Aging in 1973, established that a number of elderly persons were in inappropriate settings throughout the countryside due to the lack of a specialized approach to the multi-faceted problem of relocation trauma. The study indicated that at least 14% of the sample of persons assessed, would need relocation services in order to move from skilled nursing facilities to lower levels of care. Based upon this sample, it was estimated that approximately 104 of the Medicaid recipients residing in these nursing homes could have been relocated to a lower level of care if relocation services had been available. In addition, a survey of major area hospitals in March 1974, found 64 elderly patients who were medically dischargeable, but who remained in the hospital awaiting placement. Some remained in acute care hospitals for over two years (Kaplan and Cabral, 1980).

On the basis of anecdotal and personal observation, gerontologists have long argued that the diagnosis of organic brain syndrome is made casually, simply because the patient happens to be over a certain age (Butler, 1978). An explanation for such diagnostic behavior is that presenting symptoms of

psychiatric disturbance in the older patient will be observed in the context of a stereotype that is widely shared by all members of our society. This stereotype sees symptoms of behavioral, perceptual, and emotional disorder as an expected and normal process of aging. Since old age is regarded as progressive and incurable, disorders that are viewed as attributable to old age, will not be expected to respond to treatment (Labouvie, 1973). With such an unfavorable and pessimistic outlook on the course of a perceived progressive and organic ailment, it might be hypothesized that the individual with the diagnosis of organic brain syndrome will likely be the subject of therapeutic discrimination and not receive staff time or money needed for rehabilitative interventions.

Inaccurate use of organic brain syndrome diagnosis may involve harmful and far-reaching medical and social consequences for elderly patients. From a medical standpoint, use of this diagnosis may prevent careful and complete diagnostic work-ups of patients, thus preventing detection of the real causes of their problems and impeding treatment of potentially reversible conditions. Patients who are regarded as suffering from an organic affliction associated with the aging process are also likely to be regarded as candidates for custodial forms of care, often in the form of psychoactive medication (Green, 1978).

As a label, the diagnosis of organic brain syndrome provides a social status passage from person to patient, thereby facilitating institutionalization, absolving guilt resulting from the hospitalization of the person in light of a clear medical reason or need; and mediating the social stigma assigned to those responsible for the person when they hospitalize him/her (Baizerman, and Ellison, 1971). In addition, the label shifts the perception that others have of the patient's responsibility for his/her actions, allowing responsible others to seek legal, protective

guardianship and fiduciary relationships for the individuals which in turn permits the control of the patient's personal and real property as well as income (Mathiasen, 1963).

A study was conducted in the Northeastern United States. A group of doctors and nurses were the subjects of this study at a large (800-bed city hospital). Based on a series of factorial chi-square tests of significance for the effect of two independent variables ("age by contact") on a dependent variable, it was determined that the main effect by age was significant for diagnosis, prognosis, and intervention decisions. All tests used .05 for level of significance. As hypothesized, nurses were more likely to give a diagnosis of organic brain syndrome when the patient was depicted as elderly rather than as young. Specifically, 97% of the subjects diagnosed organic brain syndrome for the 68 year-old, whereas only 3% made this diagnosis for the condition of the 28 year-old patient (Ciliberto, 1981).

The older patient was also significantly more likely to be seen as an appropriate candidate for institutionalization. Specifically, 44% of the subjects suggested a nursing home or mental hospital for the 68 year-old, while only 22% suggested such an intervention for the 28 year-old. By contrast, psychotherapy was significantly more likely to be recommended as an appropriate treatment intervention for the younger than for the older patient. Some 59% of the subjects chose psychotherapy as an appropriate procedure for the 28 year-old patient, but only 9% chose psychotherapy for the 68 year-old patient. Consistent with other findings, the younger patient was also more likely than the elderly patient to be seen as a candidate for recovery. More specifically, 90% of the subjects believed that the 28 year-old patient would at least partially recover, but only 10% believed that the 68 year-old patient would do so (Ciliberto, 1981).

There are individuals residing in nursing homes who are not candidates for homes, as there are individuals in other types of long-term care, that should be residing in a nursing home type of facility. The evidence seems to point towards getting the elderly out of nursing homes and into less institutionalized or home placement types of environments. Nursing homes are primarily designed to meet the needs of older citizens either convalescing from illness or receiving long-term nursing services (Ellis, 1981).

There are Ombudsman Programs for the Aging and the Disabled that have been confronted with many inappropriately placed individuals. In some instances, the intervention of the Ombudsman Programs have been instrumental in securing an appropriate setting, however, there have been cases in which they have come upon seemingly immovable obstacles. These include:

1. A lack of appropriate placement alternatives.
2. Agencies faltering in their responsibilities.
3. A long-term care system which encourages the placement of persons who require unique care into an institutional setting.
4. Professional standards review organizations of hospitals which demand immediate discharge of patients no longer requiring acute care services (Ellis, 1981).

The inappropriately placed individual is not easily recognizable; special tests must be administered to determine the individual's inappropriateness. It has been found that generally the following groups of people do not need the services that a nursing home provides or the services which are needed are not provided in a nursing home setting:

1. Developmentally Disabled Persons of all Ages:

These individuals could be more appropriately served in other settings such as small group homes. In a nursing home setting where the majority of people are older and may or may not be showing some signs of mental deterioration, the type of programming that is offered is often quite inadequate and not geared for the needs of developmentally disabled individuals. The developmentally disabled persons require training to improve their personal skills.

2. Younger Cerebral Palsy or Multiple Sclerosis Residents:

Although it is clearly a myth, many lay people are under the impression that cerebral palsy victims are retarded mentally. The brain damage which has occurred is usually limited motor skill capacity. Young cerebral palsy or multiple sclerosis victims have the same needs, wants and desires of other young people. Placed in an institutional setting with older citizens, is both confining and problematic. Most of the programming in the nursing homes has not been there to meet their needs, the staff often does not clearly understand their needs and in turn treats them as other elderly residents. The individual time needed for these residents is either not given or not available.

3. Accident Victims:

Many of the same problems that a cerebral palsy/multiple sclerosis victim faces, are also faced by accident victims. The individuals are limited by their body functions but in most cases their mental capacities are intact. Clearly, their needs are not met by a system designed for older persons whose limbs are not functioning due to the infirmities of age.

4. Individuals with a Disability Due to Overuse of Drugs or Alcohol:

Specialized treatment for the initial cause of their misuse of drugs or alcohol, may at times, require psychiatric care. Placement within an institutional setting may be required but a nursing home setting is inappropriate.

5. Mentally Ill Persons Who are Generally Older:

Nursing homes are ill-equipped for dealing with mentally ill persons, especially if these individuals are violent or striking out. The protection of other residents should be paramount and unless a home is provided with a locked ward, the placement is unacceptable. The nursing home is not usually staffed with a psychiatrist, and staff often misunderstand and are not trained, and therefore, ill-equipped to handle this type of a resident.

6. Elderly Individuals who Require Only Minimal Care:

The lack of services in the community, often force elderly who only require custodial services, into the nursing homes. Title XX monies are limited, private home health agencies can be costly, and the once easy availability of nursing homes is no longer a reality nor should it be considered as an alternative for this group of individuals (U.S. Department of Health, Education and Welfare, 1978).

The dollars presently being spent for nursing home care, as well as the quality of care being provided, must be taken into consideration before there is a clear plan for the development of alternatives or a solution to the problem will not be found. The disciplines involved, including the community,

must play an active role in redirecting priorities. The priority is to place individuals in the most appropriate environment. Cost cannot be the only consideration but rather the needs of the residents are most important.

V. WHAT ARE THE BASES FOR INAPPROPRIATE PLACEMENT OF THE ELDERLY?

A. MENTAL ILLNESS AMONG THE ELDERLY

The elderly are a challenge to the long-term care system which consists of the adult home, the nursing home, the acute hospital, the senior center, the home care project, the protective services agency, and the family. The impact of the "hard to manage" elderly on the front line staff of the long-term care institutions or agencies was found to be an important variable when deciding the older person's placement status. Many of these front line staff felt ill-equipped to deal with this group in senior centers or long-term care facilities. This occurred because programs or institutional systems did not offer psychiatric components (Aronson, 1983). The elderly person with mental disorders, at times, frustrates institutional personnel. The multiplicity of problems often defy classification into the current levels of institutional care available. The older person with early dementia, for example, may be too physically intact to qualify for skilled nursing care, yet too mentally impaired to be placed in a less supervised setting such as health-related or intermediate care facilities, where he/she is required to function with some independence in the basic activities of daily living. Even if he/she is accepted into an intermediate care facility, he/she may not be suitable for that setting and may require a spectrum of added services just to maintain his/her limited level of functioning within the institution. There is no third-party reimbursement for these added services, and they, therefore, usually are not available (Aronson, 1983).

A study conducted by the National Institute of Senior Centers of the National Council on Aging (1979) regarding the "hard to manage," demonstrated that the adult home or domiciliary care facilities were not considered in any statistical analysis as long-term institutions. This study demonstrated the need for psychiatric and other support services to maintain the residents of adult homes at their maximum level of function in this less restrictive, community-based setting, and to decrease the need for repeated hospitalization of deinstitutionalized mental elderly patients. The management of patients with behavioral problems is not an issue that is unique to domiciliary care facilities. Skilled nursing facilities are not equipped for the elderly with psychiatric problems. The physical plant is designed to serve physically ill persons with relative limited mobility. Although there is tremendous variation among facilities, the staff is generally geared towards serving a physically ill population. Psychiatric services are often minimal, and staff has little or no training in behavioral interventions (Aronson, 1983).

Frailty, vulnerability, and risk for a variety of problems increases with advancing age in the elderly. These problems result from decreased physical and emotional capacities. Strained finances may be a contributing factor in many cases. As much as vulnerability does in fact increase with advancing age, it must be cautioned that chronological age by itself is not a good criteria for service need. Functional status is more appropriate. Current estimates are that almost 40% of the elderly are limited to some extent in carrying out major activities of daily living (Harris, 1978). This statistic certainly does not show the whole picture and in order to appreciate the complexity of determining a definition of a target population, the following should be considered:

1. 86% of the elderly suffer from one or more chronic illnesses, with varying levels of impairment ranging from mild discomfort to incapacitation.

2. 5% of the elderly are severely incapacitated by dementia; another 10% are mildly to moderately affected.
3. Three million elderly are estimated to be in serious need of mental health services.
4. Approximately one-third of the elderly live alone, which may make them more at risk for institutionalization in times of crisis.
5. 14% of the elderly live below the poverty level.
6. 25% of suicides in the United States are committed by persons 65 years of age or older. This is disproportionate to the fact that the elderly comprise only 11 percent of the general population (Aronson, 1983).

The physical problems that hinder the functioning of the elderly are often hampered by depression. It is estimated that 30 to 68 percent of the population over 65 will have a serious episode of depression which will interfere with the activities of daily living. Depression in older people often goes unrecognized, sometimes because the elder does not confide the feelings for fear of being thought abnormal or because she believes "feeling blue" is a natural part of growing old. Frequently, the depression is associated with the onset or worsening of a chronic illness (Quinn).

Besides depression, two other serious mental disorders frequently afflict the aged, often leading to dependency. These are organic brain syndromes, specifically, delirium and dementia. Delirium is an acute condition which is temporary and reversible if properly diagnosed and treated. It can be caused by malnutrition and dehydration, systemic disease, subdural hematomas (blood clots on the brain), ingestion of toxic substances or drugs, cerebrovascular accidents as in transient ischemic attacks, or head trauma. Delirium is often confused with dementia because the mental symptoms can be similar: disorientation, memory deficits, and disturbances of the sleep-waking cycle. Other symptoms can include hallucinations and a dazed and confused state of mind. Many of the reversible deliriums are now being recognized and treated so that they do not cause permanent damage or consign the elderly person to a nursing home. It is also less likely that they will lead to death from

mis-diagnosis or from an undiagnosed cause. If the underlying cause is diagnosed rapidly and treated, the older adult can return to the community, usually within a matter of weeks. A person with a disabling dementia can also have episodes of delirium (Butler, and Lewis, 1982).

Dementia is another organic brain syndrome. There are several types of dementia, and they are a major source of permanent, continually deteriorating and global disability in older people. One-third of those affected with dementia are so impaired in their daily lives that they cannot manage even routine activities such as bathing, grooming, dressing, or eating by themselves (Quinn, 1986). There are two major types of dementia; Alzheimer's Disease, thought to account for at least half of the dementias, and Multi-Infarct Dementia, which is associated with damage to cerebral blood vessels through arteriosclerosis (hardening of the arteries) and accounts for another 10 to 15 percent of the dementias. Approximately 20% of those afflicted with dementia suffer from a combination of the major forms while remaining dementias are caused by conditions that are more rare (Quinn, 1986). Alzheimer's disease is a major killer and has been called the "disease of the century." This disease afflicts 1.5 to 2 million Americans, and at least 100,000 people die from it every year. Alzheimer's is a disease of the old-old, because the longer we live, the more likely we are to be affected by it. Twenty to 30 percent of those who reach their mid-80's, are likely to be affected by the disease. This means that it affects more women than men because women tend to live longer (Wurtman, 1985).

Alzheimer's disease is characterized, in its early stages, by memory deficits and slight declines in many areas of intellectual and physical functioning. The disease may take 7 to 10 years or longer to run its course, and it is typically characterized by increasing incapacity.

Depression is one of the most widespread forms of mental illness among the aged. Estimates of its incidence in the over 65 age population range from 20 percent to an alarming 50 percent. According to these figures, depression is a more extensive problem than Alzheimer's disease in the elderly population. Heightened risk for institutionalization is one costly consequence of high rates of depression among the elderly. When depressed, individuals are less motivated to care for their personal hygiene and nutrition, thereby increasing their vulnerability to disease. With a depressed individual, who is withdrawn and socially isolated, the path to a nursing home is apt to be very direct and close (Chaisson, 1984).

Despite the magnitude of the problem, depression in the elderly is frequently overlooked, accepted as a normal accompaniment of the aging process or is mis-diagnosed. When treatment is neglected for any of these reasons, suicide is too often the end result (Rosenfeld, 1978). When they are depressed, the elderly usually turn to their primary physicians for help and describe their pain as physical rather than mental. The physicians usually treat the physical symptoms or, if they detect depression, prescribe anti-depressant medication. Unfortunately, most commonly used anti-depressants have side effects which aggravate pre-existing physical conditions commonly found in the older person (e.g., glaucoma, heart irregularities, constipation, and urinary retention). Therefore, even though anti-depressants may provide some symptomatic relief from the depression, they frequently create more physical problems and may contribute to the problem of polypharmacy. Instead of drugs, the elderly would benefit from a less intrusive but equally effective treatment alternative. Cognitive therapy, which has been demonstrated to be better than anti-depressant medication in the treatment of depression in middle-aged adults, may also be an effective treatment alternative for the elderly (Chaisson, 1984).

Pseudodementia is a term used to describe the syndrome in which dementia is mimicked by functional psychiatric illness and most often it is depression. This phenomenon, which is not uncommon in the elderly, may lead to misdiagnosis, mismanagement, and unwarranted institutionalization. Therefore, it is imperative that mental health professionals that serve the elderly be cognizant of the characteristics that distinguish depression from dementia. Noting the salient characteristics of the history, appearance, affects and cognitive functioning of individuals with pseudodementia and dementia can help in differentiating between the two disorders (Fittings and Robins, 1986).

Clarification of the sequences of symptoms onset may provide significant diagnostic clues in detecting pseudodementia. The history of an individual with a dementia will indicate that cognitive losses precede depressive symptomatology, whereas in pseudodementia, the reverse is true (Post, 1985). People surrounding the older person must be questioned specifically regarding the presence and duration of symptoms characteristic of late life depressions. Those characteristics include: feelings of helplessness, powerlessness, despair; pessimism, and problems with sleep and appetite. A reduction in activity is also an important diagnostic indicator of depression. The history of previous psychiatric illness should be obtained. In pseudodementia a history of previous psychiatric illness is common and in dementia, prior psychiatric dysfunction is unusual (Fittings and Robins, 1986).

An important feature that assists in distinguishing pseudodementia from dementia, is the client's perception of an attitude toward the demonstrated cognitive losses. In pseudodementia, the primary complaints are related to failing memory. The client may precisely recount instances in which memory losses occurred, emphasizing the severity of deficits often not apparent to the interviewer. In contrast, the demented clients may be unaware of readily

observable deficits. If the individual suffering from a dementia is cognizant of his dysfunction, he will attempt to conceal this from others and will rely on external props, such as notes and calendars, in order to maintain the illusion of normal cognitive functioning (Fittings and Robins, 1986).

Although mental health professionals are generally knowledgeable regarding the cardinal features of the syndromes of depression and dementia, the differential diagnosis between these two disorders in the elderly is likely to be a complex task. Comprehensive medical, neurological, and psychological testing are additional components of the assessment process. To misdiagnose an individual with a reversible cognitive disorder and consequently treat the individual as a case of dementia is one way to ensure senility (Fittings and Robins, 1986).

There are probably few areas in which there has been more misinformation and stereotyping than in discussions about the role of psychotherapy with the elderly. The 25 million elderly people are regarded as if there were a single typical older person. Psychotherapy with the elderly is no less complicated than psychotherapy with younger adults. Psychotherapy with the elderly is a recent phenomenon. Most of the literature has focused on the fact that the elderly are under-served and on the desirability of increasing service to the elderly. The elderly are underserved by psychotherapists. They account for only 2% of psychiatric outpatient clinic populations. Projections indicate that between 80-85% of elderly patients needing services would not receive them in 1983 (VanderZyle, 1983).

There are many reasons for this neglect of the elderly. The "father" of psychiatry, Freud, had a very pessimistic and negative attitude towards the elderly and their suitability for psychotherapy. This attitude, undoubtedly influenced generations of psychotherapists. Other reasons for neglect are as follows:

1. Practical considerations such as limited financial resources, mobility, and transportation problems.
2. Poor training and misinformation revealed in the fact that psychotherapists receive little formal education related to geriatric psychotherapy.
3. Prejudice (ageism) against the elderly by society and psychotherapists. This prejudice is illustrated in a study using a large randomly selected sample of practicing psychiatrists. These therapists regarded elderly patients as less appealing than younger patients with identical symptoms (Straker, 1973).

Several authors have referred to old age as a "season of loss" or as a "crisis in slow motion." However, to the extent that the therapist sees what distinguishes later life from earlier adulthood mainly in terms of more loss, a major conceptual wrong turn has been taken. Old age also adds as it takes away. Psychotherapists need not only to help older clients adjust to what has been taken away in later life, but also to mobilize their life experiences to react to what can be added. One of the things that can be added is a sense of being in touch with one's inner-imagery, inner directedness and one's spirituality. This can provide immense personal strength along with an understanding of the meaning of one's life (VanderZyle, 1983).

B. ECONOMICS: THE DECIDING FACTOR

In the face of growing expenditures for the care of the elderly in the United States due to their longer lives and the escalation of costs for intensive medical services during their last days of life, the aged medical expenses have been a large part of the rising expenditures in the health care sector. Health care costs have been rising twice as fast as any other index in the Gross National Product and are already hitting 12 percent. This continued rapid growth is related to higher medical prices (54%); population growth (10.5%) and quality increases (34.9%). The effects of population growth may become even more ominous as the present death rate data indicates

that by the year 2000, the elderly population would have increased by 32 million, or 35 percent (Williamson, Shindul & Evens, 1985).

The consequence of a general deterioration of the economy and spiraling health care costs has begun to drive more and more of our elderly citizens into poverty. The combination of increased medical costs, population growth and inflation has led to a situation where although expenditures for Medicare have increased, the actual federal contribution per elderly person has declined (Williamson, Shindul & Evens, 1985). Health expenditures per capita for the aged will exceed those for other age groups. Figures indicated that in 1978, the average health expenditure per elderly was \$2,026 compared with \$286 for children. By the year 2000, health expenditures per capita for the aged will reach \$6,024 (in constant dollars) while expenditures for children will reach \$627 (Grana and McCallum, 1983).

When the growth in the number of old people is included, total health expenditures on the aged are expected to increase from about \$50 billion in 1978 to almost \$200 billion in 2000, in constant 1980 dollars. This represents a challenge to develop innovative approaches to providing quality health care more economically. A large portion of the increased health expenditures for the elderly will be borne by federal, state, and local governments. Publicly financed expenditures for the aged will increase from \$1,165 per person in 1978 to \$3,464 per person in the year 2000. This represents an increase from approximately \$29 billion in 1978 to \$114 billion in 2000 (in constant 1980 dollars). Medicare expenditures will increase from \$893 per aged person in 1978 to \$2,655 per person in 2000, or a total increase from \$22 billion in 1978 to \$88 billion in 2000 (Grana and McCallum, 1983).

The cost of programs for the aged have emerged as perhaps the dominant factor shaping all federal spending and taxing decisions. The challenge is enormous and immediate in attempting to understand the complicated intricacies

of health care for the elderly as it relates to long-term care. Life expectancy changes of the elderly will be one of the critical issues confronting decisions to be made regarding long-term care expenditures and policies.

The 1950's were a time of relative stability in life expectancies in the United States. Since the 1970's, this country has once again witnessed major increases in life expectancy. Even at ages 65 and 85, and particularly for older women, the improvements in the last 25 years have been substantial. Unlike earlier improvements, which were due to reductions in acute and infectious disease death rates, more recent improvements reflect declines in chronic disease mortality risks. Nearly three-quarters of all elderly deaths are attributed to three chronic diseases: heart disease, cerebrovascular disease (strokes), and malignant neoplasms (cancer). Since 1968 death rates for the first two leading causes of death have generally declined, with the exception of rates of cancer mortality, especially among older men, which remain unchanged. Because disease of the heart accounts for nearly half of all the deaths among those 65 and over, changes in the structure of mortality among the elderly have largely been dictated by trends in the rates of heart disease (Ferraro, 1990).

Research estimates that mortality reductions have been accomplished by delaying the mortal impact of chronic disease. The estimate of the average age at death has increased by about 3 years from 1968 to 1982 for males whose deaths involved either heart disease or stroke. The mean age at death increased for females with heart disease by 2.27 years (to 81.6 in 1982) and for females with cancer by 2.4 years. At the same time however, the proportion of deaths at age 65 and 85 involving heart disease or cancer increased for both males and females, whereas the population of deaths involving cerebrovascular disease declined moderately for males and negligibly

for females. In combination, these estimates may suggest that our population is living longer but in a more diseased condition; that is, it is a population in which life extension has been accomplished at the expense of increased morbidity (Ferraro, 1990).

Increase in the mean age at death and survival time since disease onset, coupled with gains in life expectancy at the older ages, are likely to be interpreted by most individuals as "good news" for their own survival prospects. From a social perspective, however, these same data raise a question about the future. Will it be characterized by increasing numbers of disabled older persons with high per capita health care costs, or by larger numbers of active and well older persons? (Wise, 1990).

The answer to this question has enormous implications for health and social planning. Simply in terms of increases in life expectancy at age 65, the liability of the Social Security system between 1960 and 1985 has increased by 17% per person per year for women, who account for 60% of the elderly population. The actual increase in liability, of course, is much greater because of increases in the absolute number of the elderly (Ferraro, 1990).

Life expectancy from 1950 to 1985 at age 85 for older women increased 23.7% and is projected to increase another 29.4% during the period 1990 to 2040. During this same time, the number of women 85 years of age and over is likely to increase 67% (implying a 103% increase in the number of persons - years to be lived by persons after the age of 85). Under the most recent intermediate forecasts of life expectancy prepared by the actuaries of the Social Security Administration, male life expectancy at birth would increase to 73.9 years in 2000 and 78.1 years in 2080. Females are projected to have a life expectancy at birth of 80.8 in 2000 and 85.3 by 2080 (Ferraro, 1990).

Long-term care for the elderly in their latest years of life will account for the greatest expenditures of their health care lives. Many gerontological researchers and practitioners recognize the duality of informal and formal supports to the elderly. It is argued that the needs of the frail and vulnerable elderly are best met if there is a proper balance between formal and informal support, with each system performing the task for which it is best suited. The main source of informal support for older persons is the family. Yet research findings indicate that residing with other relatives is not the living arrangement of choice for most elderly persons. Living with relatives is typically a result of impaired health or low income (U.S. Department of Health and Human Services, 1987).

The array of services that are available to older people outside of institutions covers a broad range, including health, housing, and nutrition. Services have been designed to aid the informal caregiver structure. How these services are organized and delivered is the result of a complex web of policies and financial issues. Many communities have a substantial number of these services; however, only a limited number of communities are able to provide a complete set of services. Some of the major services provided to prevent institutionalization of the elderly include: adult foster care, home health care, foster care, hospice, protective services and respite care (Moody, 1988).

Approximately 1.4 million elderly persons or 5% of those 65 years and older are found in nursing homes at any given time. Estimates are that 2 million elderly (61% of those 65 years and over) will be in nursing homes by the year 2000. Assessments of the present overuse of nursing homes vary widely (Giford, 1988).

It has been estimated that the risk of being institutionalized is 48.2% at birth and 63% at age 65, but these estimates have been criticized on

methodological grounds. The consensus among researchers seems to be that the total chance of institutionalization before death among normal aged persons living in the community would be about 1 in 4. This figure makes it easy to understand the potentially high financial and human costs of institutionalization and the tremendous strain it may place on public and private resources in our society (Giford, 1988).

Almost one-half (49%) of the bill for care in nursing homes is paid out of public funds. The principal programs involved are Medicare and Medicaid, both of which began in 1965. Medicare (health insurance for the aged) is a federal insurance program financing a portion of the health care costs of persons aged 65 and over. Part A, the hospital insurance portion of Medicare is financed through Social Security, and nearly all elderly persons are automatically covered without paying premiums. Part A benefits in nursing homes are extremely limited. Only persons in Medicare - certified nursing homes are eligible, and benefits cover the first 100 days for those with conditions certified as requiring skilled nursing care. No benefits are provided for so-called intermediate nursing care or for custodial care. Part B of Medicare pays for such things as physician's services, diagnostic tests, and some drugs. It includes no coverage for nursing home care (Clark, 1984).

Medicaid is a joint federal-state program established to pay for medical care for low-income Americans. States set their own eligibility requirements. In general, persons who are eligible for state public assistance or Supplemental Security Income (SSI) under the federal program for the aged, blind, or disabled poor, automatically are eligible for Medicaid. Medicaid provides long-term, unlimited nursing home care without requiring previous hospitalization. Not surprisingly, Medicaid has become the principal public mechanism for funding nursing home care. Medicaid accounts for about 90% of government expenditures for nursing home care and 45% of all costs for

nursing homes in the United States; approximately 6 in 10 nursing home patients receive Medicaid payments (Ferraro, 1990).

There are 26,175 nursing homes in the United States and the great majority of these (73%) are run for profit. Although non-profit and government nursing homes comprise only about 27% of the facilities, their greater capacity (average size of 97 beds vs. 68 beds for proprietary facilities), enables them to serve about one-third of all nursing home residents (Zins, 1987).

Nursing homes may also be classified according to their certification status. About 75% of all nursing homes were certified either as skilled nursing facilities (SNF's), intermediate care facilities (ICF's), or both. ICF's constitute about 34% of all facilities and 45% of all certified facilities. Facilities certified as both a SNF and an ICF were larger (124 beds per facility), than the other facilities and thus accommodate almost 36% of all nursing home residents (Zins, 1987).

Over the past three decades, medical care prices rose much faster than prices in general. Nursing home costs have been no exception. From 1980 to 1987, nursing home charges continued to rise at a faster pace than the Consumer Price Index. Daily nursing home costs range from a low of about \$37 for custodial care to a high of about \$140 for skilled nursing care (Zins, 1987).

Old age institutions have been described as dehumanizing and depersonalizing. Nursing home critics describe many facilities as human junkyards and warehouses. Despite the unfavorable reputation of old-age institutions and the negative attitudes of elderly citizens towards them, many elderly individuals need and seek out institutional care. Usually this need is apparent to family members and/or is based on a physician's recommendation. In cases involving physical illness and/or debility, the need may be apparent to the elderly patient as well (Van Williams, 1989).

The availability of adequate and applicable home care and community services can prevent the institutionalization of many elderly patients. Family members are often very much involved in decisions concerning the institutionalization of an elderly person. Although when an aged family member is placed into a nursing home, many of the responsibilities for caring for that individual shift from the family to the institution. The Medicare and Medicaid regulations influence many of the decisions made by the family and the elderly person when looking at alternatives to institutionalization, thereby resulting in a nursing home placement (Zins, 1987).

Services that are delivered across the continuum of long-term care in attempts to prevent institutionalization are fragmented. Community based long-term care programs comprise a heterogeneous collection of agencies, institutions and programs of both a private and public nature. Eligibility is frequently determined by a means test. This can eliminate persons in need from the service delivery systems. Recent amendments to Medicare have shown increased sensitivity to connecting acute care services to long-term care services. The Omnibus Reconciliation Act of 1980 liberalized Medicare home health care benefits and made provisions for greater participation by proprietary home health agencies (Ferraro, 1990).

Medicaid benefits do attempt to meet the acute and long-term care needs of the elderly poor. Chore services, home aid, and other types of social services are now covered by Medicaid under a waiver provision if a state can demonstrate that total expenditures are not increased by the use of this type of service. Unfortunately, a recent study by the U.S. General Accounting Office found that expanded home health services do not necessarily reduce nursing home or hospital use or total services cost. Even with these changes in Medicare and Medicaid, public spending has reinforced the use of institutions for providing long-term care (Ferraro, 1990).

Most people agree that reform is needed in the current system for financing health and long-term care services for the elderly. The conflict exists between the increasing need for acute and long-term health services and budgetary constraints. Any change that the long-term care system will undergo will begin with those policies that shape and determine financing. For example, it has been recommended that Medicare simply be extended to include the types of services such as: foster care; adult foster care; hospice and etc. Some suggest a completely separate program with different funding methods, standards of eligibility, and administration. A compromise has been proposed between the two perspectives. The recommendation is that a schedule of benefits for institutional and home-based long-term care be included in Medicare. These new benefits would be paid for by transferring funds now budgeted for long-term care of the elderly and disabled under Medicaid and Title XX of the Social Security Act. A further proposal is to develop federal-state community programs to coordinate long-term care for Medicaid beneficiaries, with administration at the community or county level (Moody, 1988).

VI. POLICY AND ISSUES THAT AFFECT THE PLACEMENT OF THE ELDERLY AND SUGGESTED SOLUTIONS TO PREVENT INAPPROPRIATE PLACEMENT

What makes policy creation in the area of aging particularly difficult, is that the elements of the problem definition tend to be at opposite ends of the particular continuum in question. For example, along the autonomy continuum, personal autonomy is potentially conflictive with professional autonomy. The case where a woman wanted to return directly to her home from the hospital and her physician wanted a nursing home placement for her, exemplifies this conflict. The elder, without an advocate, often loses this battle.

Along the resource continuum, the issue of funds is another conflict area. Practitioners need more and government fiscal officials want to allocate less.

Politics are inherently conflictive. How does the typical legislator balance the interests of the elderly consumer with the provider interests, for example, of the American Medical Association, which spent \$50 million in its opposition to the passage of Medicare (Estes, 1983).

These conflictive areas are only illustrative of this turbulent policy area. Conflicts also exist within practitioners groups as to the best way to deliver services and what those services should be.

No doubt these conflicts rage in other areas such as mental health or child welfare. One basic difference between other areas and long-term care policy is the amount of public funds involved. Depending on how you count and who is doing the counting, we are talking about close to a third of a trillion dollars! This includes Social Security benefits, Medicare, Medicaid, social services, Veterans Administration, the Older Americans Act, subsidized housing, food stamps. Medicare and the elderly's share of Medicaid and social services programs, totaled nearly \$100 billion in 1983 (Estes, 1983).

In many ways, aging in America represents accumulated losses in personal autonomy. Chronic illness associated with very advanced age can turn a benign or manageable environment into a world of unintelligible garble, dim images, unappetizing meals, unsure footing, drugs, sharp edges, and forced solitude. If emotional stress and mental illness are indeed associated with a feeling of helplessness and loss of self control, it is not surprising that for many, the later years are extremely problematic. Yet, as a physician who would rather make house calls explains: relatively minor interventions can reverse a closing circle of old age. Applied holistic geriatric health care, with advice as simple as "remove those pesky area rugs," can have an enormous impact on everyday life.

Aging social policy is shaped by politics, politics are affected by ideology, and ideology is a product of assumptions about the nature of mankind and the social positions of interest groups (Callahan, 1979).

In America, personal autonomy is a valued ideal. Social systems are created and organized based upon assumptions of independent social factors in human groups - except where the aged are concerned.

The problems of the aged are largely socially constructed and based upon the notion that there is an equivalence between aging and dependency. Personal autonomy, like liberty, requires constant vigilance and if it is the nature of the human beast to suffer diminished vigor with advanced age, then the maintenance of personal liberty will require some social support (Estes, 1983).

In their attempts to function independently according to professional goals and objectives, health and human service workers often find themselves on a collision course with stated and felt needs of the very elders they are attempting to serve. We have observed the "counter-elder" situation occurs because of the nature of a particular position; because of a position's relationship to a larger institution; and because of dynamics among and between professional groups (Pelham and Clark, 1982). Even so-called public servants can become adversaries. When faced with the task of combatting the existing system to get a snow plow into an inner city neighborhood to rescue a homebound client, they had to behave as a bureaucratic guerrilla team.

During a study of hospital discharge and placement decisions, it was frequently found that professional activities ran counter to either wishes or the continued autonomous status of an elder patient. In the case of discharge planners, it was found that they almost always opt for a patient's discharge to home whenever humanly possible. However, caseloads are often enormous, time is short (discharge planners are often among the last to know about an

impending discharge), and alternatives are few. As a result, discharge planners frequently find themselves scrambling around looking for a suitable nursing home rather than putting together a service package that would have allowed the elder to return home (Pelham and Clark, 1982).

Overseeing this discharge process are the regulatory utilization reviewers. Before the era of Diagnostically Related Groups (DRGs), the main weapons of utilization reviewers were the clock and calendar. As soon as Medicare or Medicaid patients were certified as nonacute, reimbursement to a hospital moved to a lower level of payment or ceased. Now, with the DRG's for Medicare patients, length of stay is linked to a prospectively paid admission diagnosis. In such cases, hospital discharge planners charged with the task of coordinating a complex discharge and/or placement, find themselves potentially at odds with hospital administrators who are loathe to absorb the costs of needy patients, and utilization reviewers who disapprove such expenditures when time runs out. An elder patient with nowhere to go may find him/herself discharged to the street.

Even if institutional pressures do not force an untimely discharge and/or undesired placement, ultraprofessional competition and conflict over turf can easily shuffle a less than aggressive elder into a nursing home. Frail elders tend to be at risk of being placed in nursing homes unless heroic efforts are undertaken to counteract this tendency (Diamond and Berman, 1981).

Many times an elder patient is rolled out on a gurney to the nursing home while physicians, nurses, Medicaid and Medicare reviewers, social workers, discharge planners and administrators attempt to function autonomously, all in the best interest of the patient.

Although high quality patient care may be the first priority of medical professionals, there are other agenda items as well. Physicians, for example, are looking for bed turnover, unless the patient presents an interesting case.

Community-based long-term care agencies can get involved in this foray when one of their clients is hospitalized or becomes an agency client while an inpatient. Like social workers and discharge planners, case managers in the community may be the last of the last to know that a client has been admitted or discharged or both - all in the same day (Diamond and Berman, 1981).

With community-based long-term care agencies, a patient/client status presents some interesting turf problems for social service professionals. Whose patient/client is he/she anyway? Who is responsible for coordinating a discharge and placement? Are hospital social workers responsible for post-discharge follow-ups on such patients/clients? Is anybody talking to each other in the first place?

The issue of professional autonomy not only includes the elder versus the professional, but also profession versus profession. For example, a recent proposal to reform low home health agencies operated under Medicare calls for nurses, not physicians as is current practice, to certify and monitor eligibility as well as develop the plans of care. In other words, make the nurses more professionally autonomous and relegate the physician to a diagnostician and consultant (Pelham and Clark, 1982).

It must be recognized that prejudices and jealousies exist between professions. For example, in a symposium on aging, physicians advocated for multidisciplinary teams caring for the elderly. This team would be made up of specialists; namely, "...a doctor; public health nurse, or an R.N. experienced in long-term care; a social worker; and possibly, an ombudsman, etc." This physician's diction is revealing and one can probably recall stories from social workers who have had to deal with "insane" doctors (Elder Press, 1983).

Even within groups, significant conflict exists. For example, within the community-based long-term care movement, conflict centers on the emphasis of "health" or "medical" services. One sub-group calls for establishing a

continuum of care with "medical and social services." The choice between "medical" and "health" is a conscious decision. It reflects ideological tenets about what role medicine will play in the continuum of care, emphasized in the first and de-emphasized in the second. Future debates about community-based long-term care will have to settle the philosophical positions implicit in this word choice. Given the vigor with which advocates hold their positions, the debate may need some modern day Council to resolve the word choice and philosophical differences. All in all, it does not add up to one big happy professional family (Elder Press, 1983).

At the local level, the long-term care delivery system is comprised of a plurality of actors and interests which operate within a number of connected sub-systems. Efforts to form a single locus for long-term care is likely to meet with strong opposition among the provider community since they would be dependent for most of their business on the allocation decisions of that agency. While a single locus would provide the opportunity to allocate long-term care resources more effectively by changing patterns of service utilization, those agencies which might give up control, or experience cuts due to reduced use of their services, can be expected to fight efforts to limit long-term care to a single focal point. Such conflicts have already developed as a result of recent "managed health" initiatives in Massachusetts. The intensity of conflict between the home care program and local health providers over ultimate control of case management of elderly clients has influenced the state Medicaid agency to test a variety of lead agencies, based on local relationships, in their attempt to integrate Medicaid services with the state's home care program. The decision to expand models so as to use lead agencies other than home care corporations was due largely to the outcry from other interested providers (Callahan, 1981).

In addition to the need of a long-term care system that can respond to various subpopulations, the current system is under pressure for change from a variety of sources relating to the elderly subgroups. Increasing growth in the elderly population needing long-term care, increased numbers of skilled service providers and of professional subgroups in this area, and strong organizations of the elderly, have emerged on the local scene (Callahan, 1979). These forces and the changing federal and state initiatives in reducing nursing home beds, hospital cost containment, and expansion of noninstitutional services, have heightened interest among various provider types in becoming the focal point of long-term care for the elderly in the community. Hospitals, nursing homes, community health agencies and social services all have expressed interest in managing long-term care for the elderly. For some, it is a logical extension of their current goals. For others, it is a venture into a new market.

Recognizing the need to respond to variability in the local long-term care delivery system, criteria must be developed to assist states in evaluating the capacity of local providers to serve as focal points for long-term care (Callahan, 1979).

The following criteria are for the purpose of estimating the respective abilities of different types of agencies to perform the necessary patient management functions in long-term care.

1. Incentives. What attracts providers to long-term care? Are the incentives conducive to appropriate cost effective care?
2. Management capacity. What is the track record of the provider in managing complex programs?
3. Groups served. Does the provider have the ability to serve different subgroups of the long-term care population?
4. Incentives for recipient to use the provider. What attracts recipients to certain providers? Are the incentives conducive to appropriate cost effective care?

5. Scope of coordination. Can the gatekeeper or care manager provide comprehensiveness and continuity care?
6. Appropriateness of care. Will the provider emphasize a non-medical, noninstitutional approach to care?

The criteria represent a very rough attempt to estimate the respective capacities of different providers to serve as the major locus of long-term care in the community. It is meant to be illustrative rather than definitive and serves to point out the need to evaluate organizational capabilities of the different long-term care actors at the community level (Callahan, 1981).

A few brief conclusions can be drawn from an assessment of the criteria. Nursing homes are not likely to serve an expanded role in the long-term care system. Rather, they will be limited to caring for that segment of the population, the sick elderly, for whom nursing care is appropriate. While hospitals are likely to show heightened interest in expanding from acute into long-term care, the goals of large medical institutions are likely to conflict with trends to de-medicalize and deinstitutionalize long-term care; their ability to coordinate a complex system of community providers is untested. Perhaps the hospital could serve as a focal point in areas that are not rich in services. Existing home care providers seem to have better strengths to provide the kind of noninstitutional long-term care that has proven to be successful. Community health centers may become effective players since they may be best equipped to provide continuity between the acute and long-term care needs of patients. The description of different provider strengths and weaknesses, while useful, does not tell us what the various outcomes of locating long-term care responsibility with any provider would be. It is useful, however, that states should develop identifying lead case management agencies (Callahan, 1981).

Decisions as to the level of government responsible for different aspects of the long-term care system are still evolving. As the federal government

delegates more responsibility to states in the area of organizing long-term care programs, however, state governments will need information on what has worked in actual long-term care experiments.

If responsibility for long-term care continues to evolve to the states, the federal government will need to take some steps to ensure some degree of national equity. At the state level, some form of interagency mechanism must be developed to coordinate planning, departments, and programs around long-term care. The entity would be responsible for identifying lead case management agencies for appropriate placement (Callahan, 1979).

Even in the absence of these clearly defined roles for the federal and state government, we can make some positive recommendations about organizing a local long-term care delivery system. First, a social model for home care can be designed to be well targeted, efficient, and effective. Based on a concept of case management to carry out the different patient management functions and equipped with clear targeting criteria, home care systems can be limited and controllable.

Such a system can be enhanced through new ways of looking at client assessment where strengths of families and informal supports are evaluated as discriminately as individual client needs. New ways of involving clients and families in the development of care plans can minimize the amount of formal services. Much can be done by federal and state governments to develop incentives such as tax credits or tax deductions for families to take care of their disabled relatives.

The high concentration of frail elderly needing care in public housing projects suggests the need to look at new ways of organizing local level case management and service providers. Assignment of a building or neighborhood homemaker, for example, may be far more effective than authorizing a service to an individual in areas of high density.

Involvement of local consumers and citizen groups on board or advisory councils of local long-term care agencies has great potential for ensuring accountability and assuring the agency will be sensitive to local needs.

Long-term care services are already being provided to individuals at the local delivery level and, in many cases, to a great degree. Any efforts to better organize those services will require not only the knowledge gained from empirical data, but national goals and policies for long-term care that have been sorely lacking. At a minimum, the federal government's policies should ensure availability of essential community based long-term care services based on their own merit and not simply as a cost saving alternative to the nursing home (Callahan, 1979).

A variety of alternative health care programs for the elderly are presently being explored. Some of these projects are relatively new. Others are older, based on foreign models or models of care for other age groups, and still others are new only because of the creative approach used. In this category is the use of nursing homes facilities to provide other services to non-residents. In some demonstration projects, for example, older adult day-care units are provided at nursing homes. In a more innovative approach, health care for frail elderly is combined with day-care for young children. Some nursing homes have on-site nurseries, allowing for enhanced intergenerational programming (Salamon, 1986).

One question still being debated is whether, despite the great expense involved in caring for individuals in a facility, alternative care programs are more cost effective than institutions. When the cost of rent, food, and caretaker time is taken into account, facility-based care may be less expensive than care provided in the home. There is still, however, an unquestioned conviction that anything that keeps the elderly out of institutions is desirable (Lashof, 1977).

One program designed to offer an alternative to institutionalization for the frail elderly who can no longer live on their own is enriched housing. These programs consist of shared group living arrangements where a number of older adults live together and are provided with supportive services they need in order to maintain themselves in their own communities. These services include assistance in housekeeping, shopping, meal preparation, and personal care, and an around-the-clock, on-call emergency coverage program (Soloman, 1986). The program is designed to maximize the resident's autonomy, independence, and sense of privacy. These innovative arrangements may be located within ordinary, publicly subsidized or private housing. Enriched housing programs are often located in buildings that also house the well elderly.

There are various models within the enriched housing concept. In one model, one large apartment with many bedrooms is shared. Each bedroom is a private residence for the individual client. Another approach is individual dwelling units. Small apartments or studios, each with only one resident, are provided in close proximity to other such units (Salamon, 1986).

In most instances, there are limitations as to the number of units that may be devoted to enriched housing in any one building. This is done in order to preserve the noninstitutional atmosphere of the program.

Participation in enriched housing programs is usually limited to older adults who have a degree of functional impairment that would preclude independent living, yet the level of impairment may not be so severe as to require continuous nursing or medical supervision or full-time assistance with skills of daily living. In New York State, for example, low-income residents of enriched housing are eligible to receive a state supplement above the federal Supplement Security Income benefit. Until recently, this state benefit had been available to the impaired elderly only if they had been institutionalized.

A major aspect of the enriched housing approach is the emphasis placed on independence, within functional limits. Residents of such programs have their own rooms or apartments, share companionship with peers, and are provided for without the stigma of institutionalization (Soloman, 1986).

There are currently more than 600 programs in the United States offering daycare services for older adults. These services, variously titled day treatment, day hospital, and day health care, provide a variety of programs that offer support to frail, elderly community residents. Without such support these individuals would surely require full-time residence in a facility.

Daycare programs can be found in a variety of settings. They often are affiliated with medical institutions and may be on-site at a hospital or nursing home. They also often are located in community centers and senior citizen centers. There are three general goals for adult day care:

1. Rehabilitation for persons whose physical and social skills can be improved.
2. Maintenance of current level of functioning to slow or delay the deteriorative process.
3. The provision of respite for those individuals who normally would care for the client in a home setting.

Respite care, or temporary hospital care, is a program that began in England. The initial concept was to provide an institutional facility offering the same services found in skilled nursing facilities, for the same type of low-functioning, frail patient. The one major difference is the temporary nature of the institutionalization. Patients are brought to the facility and can remain in the institution for only a limited time. The amount of time spent in the facility is usually negotiated between the service provider at home, generally a family member, and the facility. There are often times when these family members, providing and supervising care for frail, ill, older

adults, need some temporary relief from the responsibility (Steinhauer, 1982). Perhaps they themselves become ill, or other family responsibilities arise, or they simply want to take a vacation. The caregiver negotiates the amount of time necessary for respite, during which time the ill family member is cared for by professionals in an institutional setting. This program offers an important alternative in preventing burnout by the family care providers.

Respite programs currently are being undertaken in the United States as demonstration projects with special grant funds. In order for such temporary care programs to become successful, reimbursement regulations may need some revision, to allow for changing the sites where care is offered (Steinhauer, 1982).

One of the least restrictive alternatives to institutional care for the elderly is geriatric foster care. The program uses private family residences for the care of elderly persons who are not related to the homeowners.

There does not presently exist one particular model of geriatric foster care. The types of programs that offer foster care vary from state to state. Despite the current piecemeal nature of these programs, there is a general consensus that geriatric foster care should reach those older individuals whose functional and emotional status could best be served in a protective living arrangement. One approach is to match the needs of the older adult client with the provider's ability to attend to that need. Here, too, in order for such programs to become successful, reimbursement for care provided in the home should be made available as an alternative to institutionalization (Steinhauer, 1982).

Two major issues face us in terms of the housing needs of our society. One problem relates to the difficulty faced by young people in finding homes they can afford and that are not too large for their needs. Single-family

zoning has produced neighborhoods of one-family homes to respond to the needs of the baby boom of the 1950's. These homes, however, no longer contain large families. The children have grown up and moved away, and the homes are too expensive for younger people to purchase, given the present economic environment. As a result of this historical event, we are confronted by the second issue: how can older adults utilize the extra space they now have in their large homes? (Hare, 1982)

ECHO housing, or accessory apartments, provides a possible solution to both of these dilemmas. Based on Australian concept of "granny flats," these apartments are designed as small, temporary living units that offer independent living for an older person while being contained within a larger home, thus, both the older homeowners and younger households can reside in the same house.

An important benefit of ECHO housing is the opportunity it presents for an exchange of income and services. Stronger, more able people can mow the lawn and take out the garbage. In return, the older adult can offer babysitting services or assist with other home chores. The overall benefits include making housing available to younger householders, while older householders maintain their own home and independent existence.

One major drawback to such programs is a legal issue. Most neighborhoods are zoned for single-unit housing only and do not allow alternatives such as accessory apartments. Currently, only the state of Pennsylvania and the towns of Westons, Connecticut; Portland, Oregon; and Babylon, New York; have legalized such housing alternatives (Hare, 1982).

It has been proven that it is cost-effective to avoid institutional care; that keeping older persons in their own homes maintains their physical and psychological well-being; that Medicaid monies have been disproportionately given to nursing homes. Therefore, the following policy recommendations need

to be initiated to prevent the inappropriate placement of the elderly into long-term care facilities:

1. Develop a community-based system of services for long-term care, including functional assessment, case management, and brokering or channeling proper services, including institutionalization when necessary, to the client and family.
2. Provide supportive services in congregate housing.
3. Encourage residents, families, and administrators to participate jointly without reprisals in policy development and decision-making regarding long-term care.
4. Redirect Medicaid money to provide more Home Based Care.
5. Institute regulations for quality care in boarding homes.
6. Reevaluate nursing home standards for the purpose of upgrading humane services without sacrificing custodial care.
7. Change state Medicaid plans to allow for payment of homemaker/home health care services, day care for adults, and respite care.
8. Allocate a specific percentage of Title XX state funds for the elderly, according to their percentage in the population.
9. Require state and comprehensive Health Planning & Development Administration to include goals and objectives in the state plans to deal with long-term care service support system development.
10. Require state Medicaid agencies to require a functional assessment to include physical, mental, activities of daily living, economic status, and socialization of an older person prior to reimbursement to a nursing home or community service provider.
11. Reduce the duplication of federal guidelines which agencies must address.

VII. CONCLUSION: FUTURE DIRECTIONS IN LONG-TERM CARE FOR THE ELDERLY

Long-term care policy of the 1980's and beyond, will continue to be influenced by the strength of special interest groups and the larger political and economic context of federal and state policy. The major federal policy shifts of reduced social spending, the revival of new federalism and block grants, and the introduction of pro-competitive health proposals will play a vital roll in determining the future of long-term care. Long-term care

along with other health and social services programs, is under intense scrutiny at both the federal and state levels, as declarations of fiscal crisis deepen at all levels of government. Fundamental assumptions about basic entitlement programs are being questioned and new policy directions are under consideration (Estes and Lee, 1988).

What began as a limited federal and state government response to a relatively small-scale need for institutional long-term care for the elderly in the mid-1930's, has mushroomed by the 1980's into a multi-billion dollar policy problem. Future care will be influenced by multiple public policies, particularly those related to such domestic spending issues as income maintenance, health care, social services, and housing. In each of these areas, states will continue to play a key role in outcomes of policy because of the variety of federal laws affecting long-term care, particularly supplemental security income, medicaid, and social service program legislation, which assigns the states' major responsibilities and affords them broad discretion in carrying out these programs (Harrington, 1985). The pressures on government are growing with the demand for long-term care services. The simple demographic fact that the U.S. population is growing older at a rapid rate is reason enough for national concern about long-term care. Demographic factors intersect with social, economic, and cultural factors, augmenting the urgency of an adequate long-term care policy. Long-term care demand is affected by such factors as the rate of economic growth, the strength of the public and private sector and the available human and institutional resources. A new national long-term care policy is needed to respond to broad social, economic, and political forces (Harrington, 1985).

To develop a national long-term care policy, certain principles should be followed. An adequate system of long-term care must include four basic elements. 1) The system of long-term care must be comprehensive, including a

full range of health and social services covering the long-term care continuum from community-based care to institutional care. 2) It must also include preventive and restorative services as well as treatment and illness management. 3) Long-term care services must be linked with other health and social services as well as with hospital and physician services. 4) An adequate system must provide incentives for providers to keep costs at a reasonable level, to prevent over-utilization, and to promote the use of appropriate services. One way to do this is to put providers at risk under capitated prepayment plans; another is to have an effective system of regulations at the state level that includes all payers for hospital, physician, and nursing home services (Pelham, 1984).

The system also must have a financial system that provides protection from impoverishment to individuals who need long-term care and that allows for combining private and public resources to assure protection for individuals before they become ill. Finally, the system must ensure access to those who need the services regardless of financial ability to pay or other characteristics. Clients must have access to the services regardless of age or disability. While long-term care is predominantly used by older individuals, it is a system for those of all ages who are disabled (Pelham, 1984).

Older and disabled individuals should have access to a comprehensive services program in addition to basic care, ambulatory care, drug coverage, and other health services. A full range of long-term care services should include the following:

Institutional care (licensed health facilities):
Rehabilitation
Skilled nursing services
Intermediate care services
Psychiatric services

Residential care (homes without nursing care):

- Group homes
- Family homes
- Personal care
- Boarding care
- Foster care
- Congregate living

Community services:

- Hospice care - for terminally ill
- Respite care - short-term care to relieve caretakers
- Day health care - health and rehabilitative services
- Day care - social program without health services
- Sheltered workshops - supervised work settings
- Community mental health
- Legal services
- Protective services
- Information and referral
- Transportation
- Case Management - coordinator of care
- Home health nurse/aide
- Homemaker chore services
- Meals
- Housing
- Combination of the above programs

(U.S. Health Care Financing Administration, 1983).

Health promotion and disease prevention are also important components of long-term care. The burden of a number of chronic conditions common among the aged such as hypertension, heart conditions, diabetes, dental diseases, and osteoporosis can be lessened through a variety of preventive approaches including diet and exercise. Much work needs to be done to inform consumers and providers about health promotion behavior and the available health care resources. Even more can be done to let consumers know about the cost, quality, and availability of services, whether or not physicians accept Medicare assignment and what they charge for their services (National Study Group for State Medicaid Strategies, 1984).

It is not difficult to agree on the elements of a comprehensive long-term care benefit package. The difficulty is in agreeing on how many and what type of service providers are needed, who is going to pay for the services, and how the system will be organized and financed. If these are the essential

components to a service delivery system, each geographic area must first determine how it stands in developing the range of services needed. In the urban and rural areas, most states do not have a full network of long-term care services. While states are beginning to develop such programs as foster care and adult day health care, the growth rate is slow. The rate of development of community-based services does not appear to be sufficient to meet the growing long-term care needs of the nation. Congressional proposals that would expedite the development of community-based service programs would be desirable. Many states have developed programs through the community-based medicaid demonstration projects which show great promise in making services more comprehensive. Incremental approaches at the state and federal level for expanding community-based long-term care options are important. Other means of providing federal funds to states for these efforts could speed the growth and development of needed programs, particularly in rural areas and in underdeveloped states (Vladeck, 1983).

Achieving the full range of services need not always mean an increase in direct total public expenditures. In many cases, expansion of services could be possible by shifting resources away from one service area to another. In spite of a lot of rhetoric about the efficacy of shifting resources away from hospitals and nursing homes, most states have permitted an expansion of acute care services and nursing home beds, at the expense of developing noninstitutional services. Since there is little evidence that greater numbers of nursing home beds are needed, states could limit expenditures in this area and direct limited public and private resources toward developing those services that are not available or that are inadequate (Luft, 1981).

The "national" policy is comprised of multiple, variable, noncomparable policies and programs, each of which vary in different states. A major question is whether particular long-term care policy goals and programs should

be determined nationally or left to state and local governments. Given the structure of current programs, a complete understanding of the "national" policy on health care for the elderly in general, or for long-term care in particular, cannot be obtained without a systematic examination of policies across states. The goal of such an examination should be to distinguish those responsibilities that are logically state and local in nature from those that are so significant and moral in impact that the inequities made possible by decentralized decision making, must be prevented through the development of a single national policy (Pelham, 1984).

The myriad state-level cost-saving strategies in health have not led to systemwide reform. The research of the Aging Health Policy Center demonstrates that, on the contrary, savings from direct cutbacks or from eligibility restrictions have not resulted in the transfer of money to social and community-based services. Often such savings merely enable states and local governments to keep pace with the overall inflation in medical care prices and the pressures on Medicaid generated by unemployment. The research further illustrates the vulnerability of the aged to capricious and complex federal and state health and aging policies, as well as to broader policy considerations, such as cost containment and decentralization of programs from the federal to state and local governments (U.S. Health Care Financing Administration, 1983).

Health administrators and policy makers must now begin to focus on the incentives for coherence and compatibility with society, and assess the impact of society on the behavior of the health system. This will first assist health administrators and policy makers in gaining a better understanding of their sociopolitical context and, second, to provide suggestions for ways of adapting to this context to improve the effectiveness of new and existing health policy initiatives. A multi-strategy approach to the problem of the

health care costs must be developed by public administrators. There is no unitary, fix-all solution, such as rationing of services or national health insurance, that a large majority of citizens currently support (Rochefort and Boyer, 1988).

Many people in business, labor, government, academia, and medicine remain deeply committed to one or another proposal, as the only solution to rising health care costs. This allegiance to single solutions stands in the way of aggressive national efforts to solve the problem. What is needed instead is fashioning of a package of policy and administrative techniques, no one component of which will serve as a panacea, but all of which could contribute effectively to controlling costs (Rochefort and Boyer, 1988).

Many components might enter into a multipronged approach. For example, public administrators can help foster further development of competitive health insurance plans. The public would approve such a strategy, at least to the extent that it included some freedom of choices among subscribers and limits on deductibles, coinsurances, and copayments. The public also is apparently ready to support new constraints on physician behavior. A limit on fees is the most direct means to do that, but it is also the crudest and almost intrusive and the one most calculated to inflame the medical community. Other, more targeted avenues to a similar end might be stiffer penalties and controls for providers who are subjects of repeated malpractice actions and monitoring mechanisms to reduce the geographic variations in professional practice that have been uncovered in small-area analysis studies. Also in order, is further development of preventive health programs: one recent national survey reported more than three-fourths of respondents favored setting up preventive care education systems to teach people how to stay healthy and recognize early disease symptoms (Williams, 1985).

Health opinion polls have surfaced the need for governmental officials to join with private sector groups in the development and application of cost-control and other health policy measures. On health care issues, as in general, the standing of public officials with the general citizenry is strikingly low. With respect to physicians and hospitals, a somewhat awkward and potentially incapacitating situation exists where the regulators inspire less trust and confidence than do the subjects of regulation (although the need for some regulation is itself widely accepted). Public managers must cultivate cooperative relationships with those elements in the business, labor, consumer, health service, and, perhaps especially, medical communities that are willing to be part of a broad coalition for oversight of the health care system. On the symbolic level, the processes of administration and policy making gain in legitimacy to the extent that they are reorganized as representatives. This perception of legitimacy, in turn, is crucial to success of new program initiatives (Rochefort and Boyer, 1988).

Public managers must contribute deliberately to advancing popular understanding of contemporary health care issues and problems. Administrative personnel must work not only to adapt to their environment but also to change it. Health administrators and policymakers everyday must make decisions based on difficult trade-offs between access, quality, and cost. Few interventions, even as idealized abstractions, can promise to maximize these three health system attributes simultaneously (Greenwald, 1988).

The process of popular education might very well begin with the dissemination of information on regionalized systems of care, the logic of which undergirds modern health planning and regulatory strategy yet apparently eludes the citizenry. Administrators should engage community members in a dialogue regarding two counterposed health care models - that of the fully elaborated, sufficient - unto-itself, local service systems whose goal is to

include even very specialized forms of care and that of the planned, hierarchical network of institutions and providers. It is understandable that most lay observers instinctively seem to prefer the former, and view the latter as designed to deprive them of valued community resources. But it is questionable how many have truly made a conscious comparative evaluation of the alternatives based on costs and benefits (Greenwald, 1988).

The United States is said to be "slouching" towards national health insurance. Another observer of contemporary health trends reaches the ironic conclusion that "the same forces advancing a competitive health care system are also indirectly moving it to a point where by the early 1990's, it will be nudged over the private sector threshold into a national system." A better informed citizenry might help decision makers decide how far to pursue this tendency and provide input into consideration of general system design issues (Wechsler and Backoff, 1986).

Public administration experts in the gerontological and health fields must lead the movement towards assuring that the elderly are included as complete benefactors of a national health plan as it is developed. The intensity of concern and impact of public administrators advocating on behalf of the elderly regarding a national health plan and other support systems, will determine the quality of our later years of life. Inappropriate placement into long-term care by institutionalization, is a vital issue affecting the economic, physical and mental aspects of the elderly. A unified effort between public officials, public administrators, gerontologists, health advocates, and including the elderly, must be devised to prevent the inappropriate placement of the elderly, through premature institutionalization.

Deinstitutionalization forced the beginning of many social services and medical programs for the elderly in the United States. Advocates for the elderly have an enormous responsibility before them and much needs to be accomplished. I certainly do believe that public administrators will need to become the core group of advocates for the elderly, to initiate the type of change that will prevent the undue suffering that so many elderly have endured.

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