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AUTHOR Trail, Ira D.
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ABSTRACT

A Federal mandate to provide comprehensive care for the aged population in this country has stimulated program planning in gerontology by mental health professionals. Introduction of the geriatric nurse practitioner into the mental health care system is viewed as one means of attempting to increase both the availability and quality of primary mental health care in the community mental health center. This nurse functions at an "intermediate level" in relationship to traditional nursing and medical roles. Her role is to assess nursing needs of the elderly, to plan and implement care, and to evaluate the effectiveness of such care. Educational preparation for certification as a geriatric nurse is discussed. A summary of the duties of this nurse practitioner in a community health center include: (1) assess health needs of patients; (2) support/ coordinate community health care; (3) counsel and teach; (4) advocate; and (5) manage patients with chronic problems. (Author/JLL)

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THE GERIATRIC NURSE PRACTITIONER IN THE COMMUNITY MENTAL HEALTH CENTER

Ira D. Trail, RN, DPH

The Federal mandate to provide comprehensive care for the aged population in this country has stimulated program planning in gerontology by mental health professionals. Of significance are the attempts being made to integrate program components into model delivery systems which have broad implications and flexibility. The wide variations with emphasis from outreach, to direct services to some type of follow-up from hospitalized based programs many times duplicate care already being given in the community. Many programs require the client to come to the setting to receive help and rely heavily on the existing professional team which has traditionally treated mentally ill people.

In 1967 Kaplan pointed to the multiple needs of the elderly and suggested that the models of care must be multi-dimensional, responding simultaneously to medical, psychological, economic, vocational and social demands of the aging population. A year earlier in 1966 Kaplan, Ford and Weiss were advocating decentralized services to move direct service delivery away from a central locus and into the community. High priority emphasized utilizing community services and assigning high priority to coordination of care and community liaison.

Attempts at counseling and consultation services for the elderly in the community have consisted of screening and referrals to existing services. This rough screening is costly in that the elderly person must make further provisions for comprehensive assessment by professionals. Moss and Lavery, 1974, describe

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Ira D. Trail

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a model which is usually "miniman intervention by an advocacy role which should be a catalyst stimulating quality medical care and service for the client."

Despite the many attempts at models and the steady increase in knowledge and awareness of the mental health problems of the elderly, very few mental health centers report other than frustrations in caring for this large segment of our population. The literature abounds with observations of inadequate, fragmented, poorly distributed, inaccessible, costly and impersonal mental health care to the elderly.

Special attention by those most interested in the elderly have focused on nursing homes. The crisis related to care of the elderly in nursing homes has been well publicized. A tragedy which many professionals are attempting to correct.

For the elderly, there is the normal process of aging with a concomitant increase in physical illness, coupled with a radical change in environment. Changes which are often frustrating and many times the resultant behavior is belligerance. A behavior intolerable to staff. Problems of decreasing strength and health, retirement and reduced income, death of a spouse, depression and suicide are but a few of the occurrences which tend to raise anxiety levels and interfere with the elderly persons ability to cope. Although many aged persons look forward to the leisure of retirement, the change in life style requires a high degree of adjustability at an age when this facility is reduced and tends to decline. Reduction in income and power contributes to a diminution of self-esteem.

It is becoming very clear to those of us in mental health that the standard treatment modalities with the standard treatment teams--consisting of psychiatrist, psychologist, social worker, psychiatric nurse and the assortment of mental health workers are not meeting the needs of this aged population which has easily been demonstrated as effective with a younger population.

I am suggesting that the answer lies in the introduction of the concept of primary care to the mental health scene. Although Community Mental Health Centers are designed principally to assist people with emotional problems and to receive comprehensive and continuing treatment in their home communities, special attention must be focused on the need for access to high quality primary health care within the mental health delivery system as well as other health delivery systems.

As presently designed, these centers have the services necessary to accomplish such tasks as screening and routing (referral) for the treatment needed, providing a full range of mental health services needed to preserve health, prevent further illness, provide the stabilizing human support needed by the aged and their families in times of crisis and assuming responsibility for the continuing management and coordination of mental health services. Community mental health centers have outreach, entry, triage and referral, clinical/technical intervention, patient education, facilitation and coordination. Unfortunately, they do not have the expertise needed to care for the aged, thus these services so necessary for primary health care are not provided for.

I am suggesting that the model for care of the aged must follow the model for primary care. A concept which implies a human services model rather than models created on strict professional disciplinary lines. No single discipline can realistically meet the range of needs of the aged consumer of mental health care. The typical model of mental health care--removed from the institution to the community will not achieve the type of comprehensive care needed for the elderly. In short, the typical psychiatric nurse, has been mal-utilized toward managerial, clerical and technical activities and does not have the knowledge or skills needed to care for the elderly in the community. Further, the typical public health nurse or visiting nurse in the community will not meet the needs of the elderly in the community mental health center. The fragmented manner in which these community nurses have had to relate to physicians, hospitals and clinics with little direct patient centered communication between them has handicapped the community nurse's ability to gain and retain clinical depth across the mental health--mental illness continuum. Independent functioning between these nurses and physicians tends to result in duplication, inefficiencies and gaps in service.

On another dimension, the need for support services for the elderly has been increased by changes in family and community structure and has resulted in less of a built in support system. At the same time, increased consumer sophistication and ability to define mental health needs has led to increased expectation and demands for mental health services.

Introduction of the geriatric nurse practitioner into the mental health care system is viewed as one means of attempting to increase both the

availability and quality of primary mental health care in the community mental health center. This nurse practitioner is conceived as a new type of health care provider, a professional nurse functioning at an "intermediate level" in relationship to traditional nursing and medical roles.

Geriatric nurse practitioners are being prepared in many large University Schools of Nursing throughout the country. This nurse who cares for the elderly in all dimensions of concern has been traditionally a primary care worker in long-term care. The natural relationship between the nature of nursing and the care of the elderly has caused many to believe that the nurse is the most appropriate and best prepared health worker to assume major responsibilities for the care of the elderly.

The American Nurses Association Standards on Geriatric Nursing Practice, 1974, describes the Geriatric Nurse Practitioner as follows:

"In her new role, as geriatric nurse practitioner, she is concerned with assessment of the nursing needs of the elderly, planning and implementing nursing care to meet the needs and evaluating the effectiveness of such care to achieve and maintain a level of wellness consistent with the limitations imposed by the aging process."

In addition, her functions include acting as an advocate and /or significant other when this is needed; sustaining and supporting patients during diagnosis and treatment; obtaining a comprehensive health history; coordinating health care and other health resources; teaching and counselling patients and families about aging, health and mental illness; evaluating the nursing process and the milieu in which care is given.

Other duties include performing physical examinations, assessing and managing

acute and chronic episodes of illnesses in the aging population within established parameters; this includes providing preventive aspects of care as well as direct patient care and prescribing and managing selected medications within established protocols.

The educational programs for this specialized practitioner includes the aging process to include theories of aging, normal aging and attitudes toward aging; increased communication skills to include dealing with sensory deficits (deafness, low vision, aphasia, etc.); counselling patients and families; community health delivery systems to include payment for such services as medicare, medicaid and private insurances; resources in the community such as protective services, psychological services, home care programs, public health nursing, counseling, clinics, hospitals, legal aid; developmental tasks to include the tasks of aging, transition, reminiscence, retirement, widowhood, relocation, changes in sexuality, process of dying and preparation for death; health programs to include the review of physiology, and diseases commonly seen in old people with emphasis on prevention recognition, maintenance, management, recognition of complications and rehabilitation; psychological content to include behavioral changes such as loneliness, depression, apathy, abusive behavior, drugs, alcoholism, acute brain syndrome and chronic brain syndrome; sociological content to include demographic data, ethnicity, income, religion, education, recreation, societal norms and roles.

The standards and functions of this practitioner have been established by the American Nurses Association. Following an approved course of study, this nurse is certified to practice as a geriatric nurse practitioner.

The role of this nurse is conceived as an interdependent function which

permits the integration of skills and resources of the mental health team for the common goal of comprehensive and continuous personal mental health services for all elderly citizens. Nurse practitioners and psychiatrists collaborating with other members of the mental health team enhance the likelihood of providing a full scope of accessible, quality primary mental health care.

Research reports on nurse practitioners, graduates of programs specifically preparing nurses for these new roles as primary health care providers have been carried out for the past few years. One of the earlier studies by Lewis and Resnick (1967) comparing nurse and physician management of patients with chronic disease in an out-patient department revealed that nurses saw patients more frequently than physicians, physicians patients were hospitalized more frequently with longer length of stay in the hospital. Since this early study, many others have examined the abilities of the nurse practitioner and suggest that the nurse practitioner is able to detect abnormal signs and symptoms and to competently manage care in health maintenance, minor illness and monitoring chronic problems. Acceptance of the nurse practitioner by consumers has consistently been reported as high (80-95%) by studies such as those mentioned. Additionally, limited patient compliance studies have reflected this. Fink, et al (1969) reported 89 percent compliance among patients seeing nurse practitioners compared with 58 per cent among families seeing a physician.

I have deliberately labored over the preparation of this nursing role to hopefully change the image of those who may have a stereotyped picture of a nurse. I hope that I have introduced to you a new professional already prepared to assume the role so needed in the care of the aged.

In closing I would like to summarize some special thoughts on how a community mental health center might use this Geriatric Nurse Practitioner.

1. Assessment of patients to better differentiate:

- a. Situational crisis
- b. Developmental crisis
- c. Effects of drug reactions
- d. Mental status
- e. Educational needs - changing life styles
- i.e. Organic brain syndrome versus situational - functional behavioral response

This type of assessment is very difficult for M.D.--he's a mental health worker on limited contact.

2. Support - coordinate community health care.

- a. **Only 5% of elderly** are in long term facilities.
- b. 95% in community -many do not know or use resources.
- c. Aging places special demands on the accessibility and availability of mental health resources.
- d. A helping relationship maybe the most important contribution--maintain dignity, independence, etc.

3. Counsel and Teach

- a. Individual and family in community
- b. Appropriate non-medical responses to behavior
- c. Effects of Aging

4. Advocate

- a. Member of Community Committees, i.e. Council on Aging

5. Manage patients with chronic problems

- a. Problems of non-compliance--due to life style
- b. M.D. often less interested in "uncurables"
- c. Assist patients in remaining "engaged" in living

I hope that I have impressed upon you the need to break out of the stereotyped treatment teams and treatment modes which will no longer work in the care of the largest population cohort in the country and in which we as mental health workers will be called on more and more to respond to.

I have introduced to you a professional who has not been imbued with the idea that the patient must come to the source of treatment, one whose very nature has provided for entrance into the homes of people and who knows how to enter homes without intruding on the privacy of the people whom she serves.

I offer this geriatric nurse practitioner to you as a challenge, for I truly believe that we must come out of our traditional mold and realize that our purpose is human services and that we must call on all who are concerned and prepared to give the best possible health care toward the mental wellness of this aging person.

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