The Inappropriate Commitment of the Aged

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The bailout of our state hospitals in the last two decades, effected by the community mental health movement and more stringent legal procedures for civil commitments, amply confirmed an old suspicion that these institutions had become warehouses for the unwanted, not true treatment facilities. Now that state hospital populations have been reduced by 50 percent and more, there is increasing awareness of the social pressures that previously had made warehouses of the state hospitals. Because of these pressures, the socially unfit are being grossly neglected or placed in the criminal justice system or returned to the state hospitals because the newly reformed commitment procedures are loosely construed by the judiciary. A prime example of the latter mechanism is the seeming inappropriate commitment of the elderly to state hospitals.

State hospital back ward populations have always included significant numbers of elderly, half of whom are diagnosed as senile dementia or organic brain syndrome.[1,2] According to an NIMH summary of selected empirical studies, perhaps as many as 22 percent of these are inappropriately placed.[3] Portnoi describes this situation as "troublesome in the United Kingdom and dramatic in the United States."[4] A number of reasons can be identified to account for these inappropriate responses of the health care system to aged persons with mental disorders.

Lack of Trained Personnel

The movement of aged patients from state hospitals to community facilities (acute-care hospitals, skilled nursing facilities (SNFs) and intermediate care facilities (ICFs)) has not been joined by increased employment by the facilities of suitably trained staff. Nursing homes across the country are severely short of qualified personnel.[5] A 1975 report by DHEW concludes: "Each of the study teams in the eight disciplines concerned with health care delivery noted an absence of orientation of personnel in rehabilitation concepts and psychosocial needs of elderly patients in the facilities they studied."[6] Training of all health personnel in geropsychiatry is recommended by this report. As Wilkins *et al.*[7] observed, the anticipated advantage of community placement for the elderly patient is totally lost without trained staff in community facilities. Generaly geropsychiatry training is not

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enough; training must clarify the therapeutic limitations and opportunities of specific settings.[8]

Traditional Separation of Medical and Mental Health Care

One can still observe the "mutual hostility and aggressive boundary control" accompanying transfer of patients between health-care institutions and within institutions.[1] "Medical care providers direct their major efforts toward elimination of *symptomatic* illness and give only minor attention to psychosocial needs," while mental health professionals focus on "social and psychological comfort" (emphasis added); Keeran suggests the remedy may be the definition of overall health-care goals in more comprehensive and compatible terms.[8]

Inappropriate Funding of Services

The number of nursing homes in the United States increased 250 percent between 1963 and 1973,[9] largely through investment of private capital.[4] Medicare provides continued care for the elderly poor. However, most state Medicaid budgets are presently underfunded,[5] a situation that could be aggravated by future federal budget reductions.[10] The simultaneous increase of requirements for credentialing of nursing home personnel will surely increase operational expenses. Funding of mental health services has been characterized by lower reimbursement rates and greater restrictions than have other health care services.[8] Indigent patients must be kept in state hospitals long beyond the therapeutic need while arrangements are made for the placement and, in particular, completing of applications for federal and state grants.[11] Meanwhile the per diem cost of state hospital care[12] is roughly twice that of nursing homes[11] and four times that of psychiatric day care[4] or private boarding homes.[13] Lack of coordination of funding between federal, state, and local agencies causes many kinds of inefficiencies whose cost in wasted resources and disrupted lives of patients is incalculable.

Lack of Interest in the Elderly

Lazarus and Weinberg state, "Some physicians, having accepted society's devaluation of and prejudices about the elderly, are reluctant to invest time and energy" in their treatment.[14] Physician visits to the elderly are "often casual and cursory, reflecting pro forma compliance with minimum state requirements."[4] This criticism is applied to psychiatrists and others.[17]

Unequal Protection of the Elderly by the Legal System

This factor is the focus of this article. Since criteria for civil commitment in Alabama are closely equivalent to those of other states, the national literature is quite relevant. The six Alabama criteria below[15] are followed by a discussion of the pitfalls of patient-management related to them. These criteria were adopted by the Alabama Legislature in 1975 after the old Code was found unconstitutional by the Federal District Court.[16]

No person shall be committed unless the Probate Judge finds the following:

1. That he is mentally ill.
2. That he poses a real and substantial threat of harm to himself or to others.
3. That the danger has been evidenced by a recent overt act by the individual.
4. That there is treatment available for the illness diagnosed, or that confinement of the dangerous but untreatable individual is necessary for his and the community's safety and well-being.
5. That commitment or re-commitment is the least restrictive alternative necessary and available for treatment of the person's illness.
6. The necessity for commitment or re-commitment must be proved by evidence which is clear, unequivocal, and convincing.

Mental Illness

Poor recognition and misdiagnosis of psychiatric syndromes in the elderly is common.[17] In a 1976 study of physicians' referrals to nursing homes, 64 percent of the patients were misdiagnosed.[18] The diagnosis of dementia is often made merely because the patient is confused, when the confusion is actually the result of an acute physical illness.[17,19] Recent studies show that 10 to 30 percent of dementia patients have an underlying physical disorder whose correction leads to substantial mental improvement.[20,21,22] Routine mental examinations will not distinguish between irreversible dementia and temporary confusional states, a critical determination for proper routing of the patient.[1] Erroneous placement of physically ill aged persons results in excessive morbidity *and* mortality.[23] Attorney and geriatrician Albert Gunn advises, "before any characterization of mental capacity is made [in elderly patients], a comprehensive investigation should be carried out to determine that no potentially correctable physical disorder underlies perceived mental disabilities."[24]

Dangerousness

In Whanger's series, one-third of the cases were transferred from community placement because of wandering or self-neglect,[23] behaviors not considered dangerous in younger patients. In another series only 42 percent were committed because of actual or threatened assaultiveness.[25] Another study found 35.8 percent of admissions to a geropsychiatric service precipitated by stress factors,[26] which once recognized might have been managed without moving the patient.

After a seven-year liaison with a home for the aged, a psychiatrist-social worker team concluded that hospitalization for behavioral problems was almost never necessary when adequate medication and psychotherapy were provided. They found that some patients with severe brain impairment "lash out at an environment with which they can no longer communicate clearly," but respond quickly to psychotropic medication.[27] Staffs of old age and nursing homes may react to difficult patients in a rejecting or punishing manner, provoking violent behavior that could be readily recognizable and manageable in place.[25]

Treatment is Available or Confinement is Necessary

The therapeutic category of a state hospital (or any hospital) depends on its attitude toward treatability of the elderly demented. The myth is widespread that "mental-behavioral symptoms in the elderly are hopeless and untreatable."[27] The diagnosis of cerebral arteriosclerosis seems to provide an adequate explanation for behavioral changes in the aged, causing them to be "shunted off."[24] One medical resident at a large state hospital voiced the typical attitude, "If you can't get a coherent conversation out of them, then they're senile. If they're senile, it doesn't matter where they go."[1]

Even if the psychiatric hospital is correctly oriented toward elder patients, transfer from community settings risks substantial increased morbidity and mortality. Rodstein, *et al.* found that 67 of 100 consecutive elderly psychiatric hospital admittees experienced increased medical and severe adjustment problems immediately.[28] Transfers to mental hospitals "tear up vital roots, and the resulting damage may be irreparable."[27] Similar adjustment problems occur when the aged are first placed in nursing homes, frequently precipitating unnecessary psychiatric hospital referrals.[27] Institutionalization of the elderly is commonly followed by their demise.[29] One study reports more than 10 percent die within 30 days after transfer to long-term care facilities,[30] but there is some variation in reporting this mortality rate.[31]

A social stigma attaches to the state hospital admission, affecting both the patient and his or her family.[32] "Older people fear mental illness and senility. Unfortunately, when their comrades acquire either label, there is rarely a feeling of identification or compassion but rather social exclusion."[27]

It is more difficult for the older patient to achieve discharge from state hospitals. If transferred from a nursing home, his or her place there is soon taken by another unless the hospital stay is unusually brief and he or she had an excellent prior conduct record.[1] Eligibility for discharge from psychiatric hospitals is determined by evidence of improvement, but "the elderly are poor performers," and have "less opportunity to demonstrate improvement."[1] Patients who show improvement after psychiatric hospital admission, do so in the first few weeks, but such improvement depends largely on an active, specific, and expectant treatment program for aged patients, without which they merely stabilize at a lower functional level[33] or die. The likelihood of successful community placement for geropsychiatric patients diminishes rapidly after three months' hospitalization.[23] In a survey of state hospitals, 80 percent indicated major difficulty in placing patients ready for discharge.[23]

Least Restrictive Alternative

When community facilities do not treat the treatable transient mental problems of the elderly, state hospital commitment quickly becomes the evident alternative for the judge who must decide. Since 1967, more elders

with psychiatric diagnoses reside in nursing homes than in all other psychiatric inpatient facilities combined.[1] It is evident from the national literature cited that these geropsychiatric cases are not skillfully managed in most rest homes, even though with proper staff training some rest homes do much better than average.[32]

For this reason, DHHS has identified skilled psychiatric nursing as "the most important vehicle of patient mangement in long-term care" facilities.[6] Federal Medicare/Medicaid regulations require nursing homes to train their staffs regarding "problems and needs of the aged ill and disabled."[34] The ready use of psychiatric and social work consultations in Pennsylvania nursing homes also has proved effective in avoiding disruptive transfers of geropsychiatric cases.[27] In the Netherlands, health service physicians must examine patients in rest homes before transfers are made.[34] In Canada foster home care is emphasized.[13] In England, depopulated psychiatric back wards are now used as day hospitals and half-way houses.[35] In fact, geriatric day care is widely provided throughout Europe.[4] On Long Island, New York, mobile geriatric screening teams have helped to prevent needless patient transfers.[33] According to Portnoi, only a tenth of those who could utilize home care are doing so because of Medicare requirements for prior hospitalization.[4] Other Medicare/Medicaid limitations force aged patients to be placed in state hospitals needlessly.[8] As Frankfather observed, "the principal routing determinants are the characteristics of organizations rather than the characteristics of the patient's pathology."[1]

Description of Study

In the course of consultation-liaison with a long-term care unit in a large state hospital, we were struck by the frequent commitments of aged persons from rest homes and, in particular, by the seeming tenuous fulfillment of legal commitment criteria in these cases. The law assures the confidentiality of commitment hearing transcriptions and therefore the tabulation of specific commitment criteria is not possible. The authors' conclusion that the commitments were inappropriate is based therefore on the overall mental/physical/behavioral status of the patients on admission and follow-up evaluation at the psychiatric hospital. This is a profile study of 72 consecutive admissions to the long-term care unit during the fifteen month period from June 1980 through August 1981.

Results

Of the 72 consecutive admissions to the long-term care unit, 45 were males with a mean age of 68, and 28 were females with a mean age of 55. Sixty-three of the admissions were 60 years old or older. Of these 63, 36 came from the committing court with a diagnosis of dementia. However, in only five cases did we find that the patient needed state hospital commitment. A recommendation for early discharge was made in 31 (86 percent) of the 36 dementia admissions. Data on these 31 cases are listed in the Table.

TABLE. Demographic and Discharge Data on 31 Patients Recommended for Early Discharge

Case No.	Age Sex	Referred By	Reason for Commitment	Date Discharge Recommended	Stay after Discharge Recommended as of 9/81
1	81 M	Nursing Home	Confused	8/80	13 months
2	75 F	Nursing Home	Management problem	9/80	12 months
3	74 F	General Hospital	Forgetfulness	8/80	12 months
4	80 M	General Hospital	Forgetfulness	7/80	14 months
5	63 F	Family	Confusion	8/80	13 months
6	68 F	Family	Evaluation	11/80	Discharged 2/15/81
7	72 M	Family	Management problem	9/80	12 months
8	72 F	Family	Confused; forgetful	12/80	10 months
9	76 M	General Hospital	Disoriented; Emotionally labile	11/80	11 months
10	78 M	Family	Wandering	11/80	11 months
11	70 F	Nursing Home	Wandering; agitated	1/81	8 months
12	71 M	Family & Gen. Hosp.	Confused; agitated	9/80	12 months
13	60+ M	Nursing Home	Management problem	7/80	Died 7/25/80
14	70 F	Nursing Home	Confused; agitated	8/80	13 months
15	87 F	Boarding Home	Agitated	12/80	10 months
16	70+ F	General Hospital	No place else would take	6/80	trial visit 1/30/81
17	73 M	Family	Wandering	9/80	12 months
18	77 M		Confused, forgetful	8/80	deceased 8/27/81
19	73 M	Family	Confused	6/81	3 months
20	65 M	Police	Medical management	7/81	2 months
21	68 M	Family	Confused; Medicare ineligibility for nursing home care	7/81	2 months
22	77 M	Nursing Home	Management problem	10/80	11 months
23	81 M	Family	Manaement difficulty; confused	6/81	3 months
24	83 M	Family	Wandering; no place else would take	2/81	7 months
25	66 F	Police	Disoriented, wandering	2/81	7 months
26	71 M	Physician	Alcoholism; confusability	8/81	trial visit 9/13/81
27	62 M	Family	Confused, disoriented	2/81	discharged 5/22/81

28	90 M	Nursing Home & Gen. Hosp.	Wandering, disoriented	3/81	6 months
29	67 M	Family	Inability to care for self	6/81	trial visit 7/27/81
30	72 F	Family	Confused; Medicaid ineligibility for nursing home	7/81	2 months
31	64 F	Family	Severe forgetfulness	11/81	11 months

Two patients were released on trial visit within one month of the recommendation for discharge, one within seven months, and two were discharged within three months. Two patients died in their first month of hospitalization. So far the average length of stay in the state hospital after discharge was recommended is 8 months; this average length of stay will surely be much longer before all the eligible patients actually leave the hospital.

Discussion

This study of geropsychiatric admissions to a state hospital generally conforms to the findings in the national literature cited. Only a tenth of the dementia diagnoses proved to be incorrect. However, a "legitimate" need for hospital commitment was found in only one case in seven. The other 86 percent are misplaced in the state hospital at great cost to the state and unestimable cost to the well-being of the patients themselves. This misplacement rate is considerably higher than the 22 percent reported by the DHHS survey.[3] This discrepancy may be mostly a matter of defining misplacement. It is readily granted that the same patient would be seen in different ways in the different stations of the system (in the family home, in the rest home, in the courtroom, in the state hospital), depending on the differing sensitivities and resources in each setting. If providing consultation-liaison services to nursing homes is a viable remedy to improve geropsychiatric services,[27] it might be best to use the mental health professionals who regularly receive these patients at the state hospitals for the task. While nursing home employees might benefit by learning more sophisticated methods from hospital professionals, the latter might benefit as well from understanding more about nursing homes. There could be more mutual agreement about what is a problem and what is misplacement. State hospital consultation-liaison teams also could visit family homes and testify in commitment hearings to reduce dysfunction of the health care system.

Our results clearly suggest that the criteria for civil commitment are being loosely construed by Alabama judges with respect to the elderly in rest homes. Relatively transient episodes of agitation are being accepted as "recent dangerous acts," and the principle of least restrictive alternative for treatment is thereby compromised. If this trend is not corrected, the state hospitals could soon find themselves again overpopulated with seniors

whose reasons for being hospitalized have been long forgotten. This was the status quo before two decades of the community mental health movement in psychiatry and the complex web of patients' rights litigation that evolved from the celebrated Wyatt case.[36]

Ten years ago this might have seemed fertile ground for reflex initiation of another class-action law suit by the Mental Health Law Project, the U.S. Department of Justice, or some other well-funded patients' advocate attorney. Now that we are seeing some of the unintended side effects and other limitations of reliance on court orders to achieve necessary reform, we may pause to seek better remedies.

Another legal approach that might obviate litigation is to obtain an Attorney General's opinion distributed to all probate judges, informing the judges that trial of antipsychotic medication should be undertaken in the rest home before allowing commitment procedures to advance. It is quite possible that the probate judges simply do not know that such procedure is possible. This raises a larger question about whether the probate judges should be required to inform themselves on such questions by routinely calling psychiatric experts in all commitment cases.

The nature of rest homes and convalescent hospitals, the so-called transitional facilities, needs to be considered. An agitated patient may appear far different to the staff and operators of these facilities than to a psychiatrist in a formal psychiatric hospital. The psychiatrist would readily manage the problem with a change in medication and possibly a few simple changes in milieu such as better lighting, a six-foot fence, or more activity therapy. Facility staff, on the other hand, are not trained to diagnose or prescribe for problem patients; they do not have ready access to a psychiatric consultant and may not be visited by any physician more than weekly. Facilities that call physicians too often are not recommended to potential patients and their families by the doctors. They are answerable to the facility owners and to the concerned relatives of other patients for any damage or injury inflicted by an agitated patient. They are expected to have a pleasant, peaceful atmosphere in the facility, at least when visitors are present; a distasteful atmosphere could easily cost them new referrals. Complaining neighbors could cause the facility to be relocated at great expense. It is not easy to provide a fence, or other security arrangements, that would keep disoriented patients from wandering off and at the same time appear innocuous to the outside world. In short, the operators of these facilities are in a competitive business, quite unlike the state hospitals and community mental health centers. Attempts to reform their procedures must reasonably comprehend the realities of their existence.

If there were litigation forcing local judges to apply the commitment criteria more strictly, could we expect the facility operators to institute new training programs for their staffs, to arrange for ready psychiatric consultations, to increase security arrangements, all at substantial expense without a corresponding increase in Medicaid reimbursements? A more likely result

would be that the patients would be returned to their families—who are not prepared to receive them—or sent to an emergency room for admission to a district hospital that is not set up to keep patients who are essentially placement problems. Such litigation, intended to benefit these elder patients, would actually cause them more distress and provide less effective services from a disrupted system, at a much greater cost to taxpayers.

Perhaps the most important lesson of the recent history of "belegaled" psychiatry[37] is that reform of mental health system problems requires a systems approach, because a change in one sector usually shifts a service burden to another sector that is not prepared to handle it. Since the very nature of the judicial process is to redress a specific grievance (and not to provide systematic reforms), we should look to the executive branch of government for adjustments of the mental health system. Thus the plight of these elderly agitated patients would best be managed by the state mental health department. If all rest homes are required to provide additional services to this type of patient, and if the state provides the necessary resources to support the additional services, these unnecessary and possibly illegal commitments could be avoided. Because the added cost of unnecessary hospitalization is considerable, it might actually be less expensive for the state to provide better training and supportive clinical services to rest homes than to continue the existing arrangements. However, as Weisbrod *et al.* caution in their economic benefit-cost analysis of alternatives to state hospitalization: (1) profitability is neither an available test nor an appropriate test of the wisdom of allocating resources to a particular program . . . (2) government policy should, from an efficiency standpoint, be concerned not with flows of money per se but with the use of limited real resources that are needed to produce socially useful goods and services.[38] Cost-benefit analysis, for the purpose of organizing knowledge, is appropriate, but the authors as well as others[39] lament that so few controlled experiments have been conducted to investigate the economics of alternatives to mental hospital treatment.

Aggrieved persons may have to resort to litigation for relief, and we expect the judicial process to do what it can to provide proper relief. However, we cannot expect from courts the management services and leadership that should be coming from the executive arm of government.

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