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Geropsychiatric Nursing Practice in the United States: Present Trends and Future Directions

Merrie J. Kaas and Elizabeth Beattie

*Demographic trends, diversification of geriatric health care service settings, and advances in education and science call for redefining the context and mission of geropsychiatric nursing (GPN) practice. The challenges of providing preventive, restorative, and palliative care for older adults who move across health care and residential settings demand that geropsychiatric nurses be theoretically well grounded, family centered, expert in multiple assessment skills, and clinically adept across the full biopsychosocial spectrum. This article provides "snapshots" of the educational and career paths that led four nurses into GPN practice. Noting that the extant literature is more descriptive of practice models than suggestive of efficacy, the article offers a series of recommendations that emphasize the need for evaluations of GPN practice. **J Am Psychiatr Nurses Assoc, 2006; 12(3), 142-155. DOI: 10.1177/1078390306292161.***

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On its emergence in the United States in 1971, geropsychiatric nursing (GPN) was viewed as a subspecialty of both psychiatric and gerontological nursing (Harper, 1986). The field has matured as a specialty that responds to needs unmet in either psychiatric or gerontological nursing and provides expert leadership to both of its "parent" specialties. Today, the burgeoning mental health needs of an aging public demand that GPN strive to enhance both its visibility and effectiveness.

The purpose of this article is to describe the current state of GPN practice and to identify future challenges and opportunities. Other articles in this series address GPN education and geropsychiatric research. Specific aims of this article are to (a) review recommendations for practice as set forth in previous assessments of the field, (b) review contemporary demographic data to

define the context of GPN practice and identify future needs, (c) provide an illustrative snapshot of practice today, and (d) identify continuing and unique opportunities and challenges for the future of GPN practice.

RECOMMENDATIONS OF PREVIOUS "STATE-OF-THE-STATE" PAPERS

The demographic shift toward an increasingly older population with many unmet mental health care needs has underscored a predicted severe shortage of specialized, highly educated professionals (Borson, Bartels, Colenda, Gottlieb, & Meyers, 2001; Jeste et al., 1999). Prior efforts to assay needs and resources in the field have generated useful recommendations, including educational initiatives, clearer identification of the context and "consumers" of GPN practice, the need to promote cost-effective models of mental health care for elders, and advocacy for the increased funding necessary to expand the research base of GPN practice.

Both psychiatric and gerontological nurse leaders have called for more nurses educated in GPN. Murphy and Hoeffler (1987); Fopma-Loy (1989); Joel, Baldwin, and Stevens (1989); Whall (1990); Richards (1994); and Harper and Grau (1994) recommended integrating content about the care of older persons with acute and

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chronic mental illnesses throughout undergraduate and graduate nursing curricula in psychiatric and gerontologic nursing so that all nurses, regardless of practice setting, would have the skills and knowledge to care for older adults with mental health care needs. Abraham and Buckwalter (1994) promoted more vigorous integration of the biopsychosocial perspective into new models of practice that emphasize preventive, restorative, and palliative care for older adults who move across health care and residential settings.

Richards (1994) defined *GPN practice* as providing care to persons who have an identified mental illness or dementia as well as those at high risk for mental health problems in settings extending from the community to nursing homes (NHs). She described the specialty as interdisciplinary, collaborative, well grounded in theory, family centered, and expert in multiple assessment skills. Harper and Grau (1994) have noted that family caregivers also are consumers of GPN services.

Joel et al. (1989) and Richards (1994) urged development of innovative models of GPN practice that are cost-effective and clinically efficacious, promote the highest level of functioning, and meet the emerging demographic realities of the elderly population.

THE DEMOGRAPHIC IMPERATIVE

The number of persons aged 65 years and older with a major psychiatric illness is projected to reach 15 million by 2030 and overwhelm available mental health services (President's New Freedom Commission on Mental Health, 2003). This population will have several subgroups with special needs: (a) those with a lifelong history of severe and persistent mental illness, (b) those experiencing a newly diagnosed mental disorder in late life, and (c) those with psychiatric and physical comorbidity. Depression, dementia, substance abuse, and anxiety disorders are among the conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) as most prevalent in the older population (U.S. Department of Health and Human Services, 1999). Suicide is a public health crisis among elder adults, with persons 65 years and older accounting for 18% to 21% of all suicide deaths in 2000 (Jamieson, 2004; Persky, 2004). Recurrent major depressive disorder, often linked with complicated bereavement and chronic physical illness, is most strongly associated with suicide in late life (Roszak, 2004; Waern, Rubenowitz, & Wilhelmson, 2003). Persky's (2004) report that 20% of elders who completed suicide had seen a primary care provider

on the same day and 40% within the prior week underscores the need for clinicians who understand the interplay of the aging process and mental illness.

Although many nurses have been prepared in one or the other of the relevant specialty domains, a synthesis of knowledge and skills is imperative for providing responsive mental health care to older adults. Maiden (2003) identified the paucity of trained personnel as the first barrier to use of mental health services by older adults, a view supported by the New Freedom Commission on Mental Health in its call to improve training for practice in geriatrics and mental illness. Yet attracting nurses to gerontological and psychiatric nursing practice continues to be challenging. In 2002, less than 1% of the 2.56 million registered nurses were certified in geriatrics (Alliance for Aging Research, 2002). Between 1991 and 2001, only 4,200 (about 5.6%) of 70,000 to 80,000 advanced practice nurses received gerontological certification (West, 2001). Only 16% of psychiatric nurses have a subspecialization in geriatrics (Bartels, 2003). Initiatives funded by the John A. Hartford Foundation have increased significantly the numbers of well-prepared gerontological faculty and scholars and have contributed to improving gerontological practice knowledge among both specialist and nonspecialist registered nurses. Neither gerontological nor psychiatric specialties, however, have invested adequately in GPN.

SEARCHING FOR GPN PRACTICE LITERATURE

This article addresses current and future nursing practice and models of GPN care. The authors searched the CINAHL, PubMed, Academic Search Premier, and PsycINFO databases for the period 1990 to 2005 to locate published reports of GPN and practice models in the United States; in an effort to expand the number of identified articles, subsequent searches reached back to 1985. Multiple search terms yielded several hundred citations, relatively few of which related specifically to GPN practice. Verifying involvement by a nurse in the authorship reduced this pool of publications into four groups focused on (a) actual or simulated case exemplars of GPN practice, (b) descriptions of specific mental health care needs of the elderly population, (c) reports of model programs, and (d) descriptions of educational and clinical programs that support the development of novice nurses. An additional 27 international articles, primarily from developed nations, addressed mental health care of elders, but few discussed the specific role of GPN.

The authors posted a brief online survey to the American Psychiatric Nurses Association Geropsychiatric Nursing Council Web site to solicit first-person accounts of practice. That effort yielded four commentaries that describe GPN practice in various clinical settings.

CURRENT CONTEXTS AND MODELS OF GPN PRACTICE

In an early article, Fopma-Loy (1989) suggested that GPN identify its contextual base and “go where the consumer is,” which she identified at the time as NHs and single-room occupancy hotels. Today, nurses provide mental health care to older adults in diverse settings: long-term care facilities (including special dementia care units), hospitals, community clinics, home health care practices, and nontraditional settings such as prisons and homeless shelters. Despite progress in developing models of GPN care in long-term care settings, community-based settings, and home care services, there persists a dearth of literature about who provides mental health care to older adults in other important settings and how that care is delivered.

Long-Term Care

NHs. The high prevalence of psychiatric and behavioral disorders occurring in NHs is largely attributable to the deinstitutionalization movement of the mid-20th century (American Geriatrics Society and American Association for Geriatric Psychiatry, 2003a, 2003b; Geller, 2000). Reanalyses of 1977 National Nursing Home Survey (NNHS) data indicated that approximately 668,000 chronically mentally ill patients resided in NHs. It is reasonable to conclude that many deinstitutionalized elders had been discharged to NHs; indeed, the 1985 NNHS found that 4.5% of all NH residents, or 67,000 individuals, had been admitted from mental health facilities during the course of that year. Over the next decade, the number fell to less than 27,000 (1.8%), reflecting changes in the NNHS that excluded transfers from specialist inpatient psychiatric units in general hospitals (Mechanic & McAlpine, 2000) and the impact of the Omnibus Budget Reconciliation Act of 1987. The latter included mandated preadmission screening to ensure that only residents in need of nursing care be admitted to NHs but not those with a primary mental illness in need of active mental health treatment (Marek, Rantz, Fagin, & Krejci, 1996; Snowden & Roy-Byrne, 1998; Snowden,

Sato, & Roy-Byrne, 2003). Under the Omnibus Budget Reconciliation Act, dementia-related conditions remained eligible for admission (Eichmann, Griffin, Lyons, Larson, & Finkel, 1992; Freiman, Arons, Goldman, & Burns, 1990; Mechanic & McAlpine, 2000).

The 1999 NNHS found 1.6 million residents aged 65 years and older living in NHs, approximately 47% of whom were 85 years and older. Since the mid-1980s, several investigators have found a high prevalence of mental illness among NH residents (Chandler & Chandler, 1988; Parmelee, Katz, & Lawton, 1992; Tariot, Podgorski, Blazina, & Leibovici, 1993). Mechanic and McAlpine (2000) found estimates of NH residents with a mental disorder other than dementia to range widely, from less than 8,000 to more than a million. The results of the 2004 NNHS were not available at this writing.

NH residents with mental illness and dementia present special clinical challenges such as confusion, resistance to care, communication difficulties, agitation, wandering, sleep disruptions, and resident-to-resident abuse that are well documented (Algase, 1999; Beattie, Song, & LaGore, 2005; Doody et al., 2001; Shinoda-Tagawa et al., 2004; Souder, Heithoff, O'Sullivan, Lancaster, & Beck, 1999; Whall & Kolanowski, 2004). An extensive literature on the rates of staff turnover in NHs attributes some of the turnover to the difficulty of dealing with behavioral issues (Cohen-Mansfield, 1997; Gates, Fitzwater, & Meyer, 1999; Harrington et al., 2000; Morgan, Stewart, D'Arcy, Forbes, & Lawson, 2005; Tai, Bame, & Robinson, 1998). The American Health Care Association (2005) recently reported turnover rates of 71% among certified nursing assistants, 49% among registered nurses, 49% among licensed practical nurses/licensed vocational nurses, and 43% to 47% among directors of nursing and registered nurses with administrative duties.

One review of mental health care in NHs described three models: psychiatrist centered, multidisciplinary team, and geropsychiatric nurse centered (Bartels, Moak, & Dums, 2002). GPN models generally include key elements of direct care services, case coordination, and ongoing staff training and consultation. Smith, Mitchell, and Buckwalter (1995) described a model designed to increase the capabilities of NH staff to provide mental health care in which geropsychiatric clinical nurse specialists (CNSs) trained NH nurses who then became the mental health care trainers/experts in their own facilities. Although the geropsychiatric CNSs were available for ongoing telephone and on-site consultations, these services were underused by the newly trained NH nurses because

of a perceived lack of administrative support for the new role. Still, outcomes research points to the potential effectiveness of this model (Smith, Mitchell, Buckwalter, & Garand, 1995).

Another study described a geropsychiatric nurse practitioner consultation service established to provide the residents of five NHs with on-site assessment and follow-up treatment for behavioral and psychiatric problems within the Omnibus Budget Reconciliation Act and Medicare guidelines (Eisch, Brozovic, Colling, & Wold, 2000). In a 1-year period, 175 residents were evaluated after referral by NH staff for agitation, disruptive behavior, depressive symptoms, or decline in activities of daily living. Of these patients, 45% had depression, 29% had dementia with psychosis, and 11% had another psychiatric condition. An evaluation of this program documented that the geropsychiatric nurse practitioner recommendations resulted in positive behavioral changes in 62% of residents. At the end of the study period, 99% of the primary physicians approved of the consultation service, strong testimony to the nurse practitioners' success in negotiating collaborative practice around psychotropic medication management and staff education in the NH setting.

Assisted living facilities (ALFs). With the burgeoning popularity of the ALF, and the minimal regulation of such facilities for health care issues, increasing numbers of elders with mental health problems are using these settings. Recent reports suggest that rates of mental illness among elders in ALFs are comparable to those in NHs (Cummings, 2003; Gruber-Baldini, Boustani, Sloane, & Zimmerman, 2004; Rosenblatt et al., 2004; Ruckdeschel & Katz, 2004). In a random sample of 193 ALFs in Florida, Maryland, New Jersey, and North Carolina, Gruber-Baldini et al. (2004) found that of 2,078 residents ages 65 years and older, 50% had a medical diagnosis of dementia, 14% had depression, and 13% psychosis. Rosenblatt et al. (2004) reported similar rates of mental illness in randomly selected ALFs in the Baltimore area but found that 42% of ALF caregivers failed to recognize residents who were judged by a professional consensus panel as having a psychiatric illness. Bonnel (2002) suggested that ALFs are ideal settings for advanced practice nurses to promote residents' function as well as support the ALF staff and improve mental health and health care to the residents. Although these data underscore the need for appropriate GPN care for those with mental illness living in ALFs, the current literature reflects no pertinent examples of models of GPN in ALFs.

Special care units (SCUs). These units within NHs have grown rapidly in recent decades, with most specifically designed to provide enhanced physical and social environments conducive to supporting residents with cognitive and functional loss (Berg et al., 1991; Mentis & Buckwalter, 1998; Teresi, Holmes, & Ory, 2000; Wagner, Teri, & Orr-Rainey, 1995). In 2000, approximately 22% of NHs had an SCU (Leon, Cheng, & Alvarez, 1997). The National Institute on Aging has examined the goals and impact of SCUs (Teresi et al., 2000), yet precisely how to measure the impact of environmental enhancement on residents with dementia remains an urgent research question, given persisting concern that cognitive decline may be a negative outcome of environmental segregation (Van Haitsma, Lawton, & Kleban, 2000). SCUs are a natural context for geropsychiatric nurses with expertise in dementia care (Kovach, 1998), yet models for GPN practice in these environments are not described in the literature.

Hospitals

Emergency departments (EDs). Adults ages 65 years and older are the highest users of hospital-based emergency services in the United States. In 2002, 24% of all older adults made at least one ED visit in the prior 12 months, and 8.3% made at least 2 ED visits, with the frequency of visits higher for those ages 75 years and older (National Center for Health Statistics, 2004). Although we know that older adults are high users of EDs, there are no data about the number of these visits that are for psychiatric reasons. The high use of EDs and inpatient services suggests that the reasons for ED services may be psychiatric couched in somatic symptoms. Barriers to comprehensive psychiatric assessment and to adequate care of older adults in general hospital EDs include attitudes of staff toward elderly patients who present to the ED with behavioral problems or cognitive impairments, inadequate time for comprehensive evaluations, and the lack of accessible geropsychiatric specialty care (Colenda, Greenwald, Crossett, Husain, & Kennedy, 1997; Simson & Wilson, 1982). There is a paucity of literature describing GPN practice in hospital or free-standing emergency units, and there are no models of GPN care in EDs described in the literature.

Inpatient settings. Elders are high users of hospital inpatient settings. In 2002, persons ages 65 years and older and 75 years and older had hospital discharge rates of 293 per 1,000 and 343 per 1,000, respectively, in contrast to the average discharge rate

of 122 per 1,000 in the general population (National Center for Health Statistics, 2004). Unfortunately, little data exist that describe the mental health care needs of older adults hospitalized on general medical units. General hospital discharge rates for older men—but not for older women—with a primary diagnosis of serious mental illness increased with age (National Center for Health Statistics, 2004).

Psychiatric hospital admission from an ED or community setting may pose clinical disadvantages for elders. Yazgan, Greenwald, Kremen, Strach, and Kramer-Ginsberg (2004) found that a statistically significantly higher percentage of older patients on a specialized geropsychiatric hospital unit received more comprehensive physical and cognitive assessment, more medication and side effect monitoring, and more specific discharge referrals than did geriatric patients on a general psychiatric hospital unit. Specialized geropsychiatric units using multidisciplinary teams have demonstrated positive physical and mental health treatment outcomes (Kujawinski et al., 1993; Ngoh, Lewis, & Connolly, 2005). The need to identify both medical and psychiatric patient outcomes is especially important in light of the increasing medical comorbidities of geriatric psychiatric patients on inpatient units today (Colenda et al., 1997).

To identify best nursing care practices provided by geropsychiatric hospital units, in the absence of a formal directory, Smith, Specht, and Buckwalter (2005a, 2005b) surveyed units identified by means of personal contacts with professional colleagues and organizations. Based on returned surveys from 31 contacts, the authors described the difficulty in finding staff qualified to meet the complex care needs of patients with both medical and psychiatric diagnoses. Challenges in caring for the older psychiatric patients on these specialized hospital units included educating staff, managing the level of patient acuity, and finding appropriate discharge placements. The major strength of these units was the dedication of the staff working with older patients.

Two models that can maximize positive clinical outcomes for hospitalized elders with mental health needs are presented here as exemplars: a geropsychiatric team within an existing psychiatric unit and a psychiatric consultation–liaison nurse (PCLN) in a general hospital. Nadler-Moodie and Gold (2005) described a “geropsychiatric unit without walls” within an existing adult psychiatric unit. This unit, called the senior team, was designed and developed by a multidisciplinary team in response to the closure of two area geropsychiatric programs. Changes to the existing unit structure included increasing

the time for a comprehensive assessment to evaluate the patient for participation in program activities, reevaluating discharge treatment benchmarks in light of the co-occurring medical and psychiatric conditions, developing staff expertise, adding groups that focused on older adult issues, and redesigning the physical spaces to meet patients’ needs. At the end of 1 year, 80% of the staff reported that they had the skills necessary to work with geropsychiatric patients and that clustering the patients was positive. Since the development of the unit without walls, the fall rate was reduced, there was no use of restraints, and there were no deaths on the unit. Remarkably, this model was implemented within physical, financial, and staffing requisites.

The PCLN model includes consultation, collaboration, education, and direct patient care for clients and families on general hospital units. As a PCLN, Kurlowicz (2001) retrospectively audited the consultation records of 103 older adult patients with mental health needs, hospitalized on general medical units, whom she had seen over 12 months to describe the outcomes of the PCLN interventions. Staff evaluation of the PCLN’s helpfulness was obtained using a two-item questionnaire. Patients were referred to the PCLN by the nursing staff and were screened for delirium and depression using standardized instruments. Interventions followed individualized protocols established and implemented by the PCLN and nursing staff. The PCLN conducted discharge clinical assessments. Outcomes included a significant decrease in depression and delirium from admission to discharge. Staff also reported benefiting from the PCLN interventions. This model of geropsychiatric care is founded on an established advanced practice role, uses the skills of the geropsychiatric nurse to improve treatment outcomes of complex hospitalized patient conditions, and builds the competencies of existing staff to manage the complex nursing care needs of geropsychiatric patients. Santmyer and Roca (1991) used a PCLN model to provide mental health care to NH residents and found that the PCLN, rather than a psychiatrist, could manage the majority of referrals. PCLNs also have assumed care for older adults living in the community.

Community Settings

A majority of older adults live in their homes, albeit frequently with mental health problems. In 2001-2002, 2.4% of community-dwelling persons 65 years and older reported indicators of serious mental

illness, meaning that they felt sad, nervous, restless or fidgety, hopeless, that everything was an effort, and worthless some to all of the time (Centers for Disease Control and Prevention, 2004). Those elders at high risk for mental health problems and those already diagnosed with psychiatric disorders need mental health care, which increasingly is provided in the home.

Home care. The 2000 National Home and Hospice Care Survey found that 70% of 1.35 million home health care patients were age 65 years and older, and as age increased, so did the use of home care services (Centers for Disease Control and Prevention, 2004), which is rapidly becoming a major context for GPN. Of the 955,200 elder home care patients in 2000, 33% received psychosocial services including counseling, psychological and social services, spiritual/pastoral care, and referrals to other psychosocial services.

The GPN literature provides many examples of psychiatric home care for elders (Kozlak & Thobaben, 1994). Felten (1997) described a collaborative approach among home care nurses, the geropsychiatric CNS, and other health care professionals wherein the home care nurse was the gatekeeper; the CNS was the specialist in mental health triage, treatment, and staff development; and other professionals were the support team, providing resources to help older adults remain in the home. Felten identified that essential knowledge and skills derive from psychiatry, gerontology, medical/surgical, community health nursing specialties, and pharmacology. Moore, Browne, Forte, and Sherwood (1996) and Freed and Rice (1997) described mental health services that can be delivered by generalist home care nurses and the issues related to developing a home care program for older adults with mental health needs. Two other models offer descriptions of advanced practice nurses in home care. Dellasega and King (1996) discussed specialized home care services for older adults with cognitive impairment and the role of the geropsychiatric CNS in the home care agency. Mohit (2000) reported providing family therapy to psychiatric home care patients using the developmental-interactional model of family therapy. Although all these geropsychiatric models of practice were very different, two successful key elements in common were the collaboration with other providers and families and staff education.

Farran, Horton-Deutsch, Fiedler, and Scott (1997) conducted a descriptive, retrospective chart review in 1994 of geropsychiatric home care patients from both sites of a large Chicago home health care agency. Demographic data and a description of nursing interventions were available for all patients. The

authors reviewed a subset of 20 charts of depressed Medicare recipients to obtain information on caregivers, hospitalizations prior to home care, length of home care stay, discharge from home care, and use of home care services. Findings highlighted the difficulty in determining what interventions constitute specific geropsychiatric home care versus standard home care interventions. Research on the effectiveness of specific interventions by geropsychiatric nurses versus standard interventions provided by other nurses is sorely needed.

Outreach services. Although home care has received much attention, other community settings have begun to develop models of care for reaching out to older adults with mental health needs. In a systematic review of the research, Van Citters and Bartels (2004) summarized the effectiveness of various types of community mental health outreach services to elders to increase access to mental health services and improve psychiatric outcomes. Of 162 articles found, only 14 met inclusion criteria, which were face-to-face psychiatric services with persons ages 65 years and older with mental illness and studies designed as randomized controlled trials, quasi-experimental outcome studies, uncontrolled cohort studies, or comparisons of two or more interventions. The authors found that the gatekeeper model (use of nontraditional referral sources, for example, utility workers) as opposed to the traditional model (use of medical providers, family, caregivers) tended to find people who were more isolated and who were not as likely to get mental health or social services from traditional approaches. A majority of studies supported the effectiveness of home and community outreach services to improve psychiatric outcomes. Although methodologic issues limited the generalizability of findings, this review demonstrated the range of community outreach services available and associated treatment outcomes.

The role of the nurse in outreach models is not always easy to discern. An exception is the psychogeriatric assessment and treatment in city housing model (Rabins et al., 2000; Robbins et al., 2000), a nurse-based outreach program developed in Baltimore that combines approaches from assertive community treatment and gatekeeper models of outreach. The psychogeriatric assessment and treatment in city housing model uses a proactive, mobile approach to target a high-risk public housing population by using gatekeepers for case finding while relying on psychiatric nurses to provide initial assessments, collaborate with the multidisciplinary team in developing a treatment plan,

deliver case management and direct care services, and provide staff education. Results from a randomized controlled trial designed to compare the model intervention with usual care to residents of six public housing buildings demonstrated the effectiveness of this type of nurse-based outreach in reducing psychiatric symptoms in persons with psychiatric disorders and those at high risk for developing disorders.

Rural elders are a high-risk population for mental illness and are underserved by mental health care providers. They have higher rates of depression and suicide, yet underuse health and mental health services (Chalifoux, Neese, Buckwalter, Litwak, & Abraham, 1996; Neese, Abraham, & Buckwalter, 1999). Two models of nurse-centered mental health outreach to older adults in Iowa and Virginia reported positive client outcomes and case findings (Abraham et al., 1993). Although the client population differed, both of these programs used nurses for home assessment, direct in-home services, and case management.

Outpatient settings. Despite extensive medical and psychiatric comorbidity in older persons, health systems have not adequately addressed these complex needs in primary care. Primary care models have been developed to coordinate services across specialty areas (Bartels, 2004), from multidisciplinary teams to single providers who deliver both medical and psychiatric care. In a review of the most recent randomized controlled trials testing various models for the assessment and treatment of geriatric depression in primary care, Kaas (2005) found that the role of nurses in providing mental health care in any of these models received little attention.

An exception was the depression care specialist (DCS) role developed for the Improving Mood: Providing Access to Collaborative Treatment Study (Unutzer et al., 2002). The DCS was developed as an integral component of an intervention used in a multisite randomized controlled trial of a disease management program for late-life depression. Saur et al. (2002) described the role and function of the DCS and suggested how the DCS could be integrated in other primary care settings.

Abraham et al. (1991) described the Geriatric Neuropsychiatry Clinic, which used a multidisciplinary team to offer comprehensive assessment, provide direct treatment for psychiatric symptoms, provide a training environment for health professional students, and develop opportunities to collaborate across disciplines. The clinic was held 1 day per week in an outpatient adult psychiatric clinic and

was led by nurses who did the initial assessments, coordinated care, and provided direct treatment. The clinic also provided family and caregiver education and support.

A less intense but comprehensive model of geriatric mental health care is the geriatric day hospital, adapted from the British model of geriatric day care. The single geriatric day hospital model found in the U.S. literature was developed in a community hospital in San Diego to meet the complex needs of frail elders, including their mental health needs (Morishita et al., 1989). The geriatric day hospital provided comprehensive multidisciplinary assessment, care coordination, and case management by a team of professionals that included nurses.

Nontraditional Settings

Although the community is fast becoming the major context of care, nontraditional settings such as prisons and homeless shelters also attend to older adults with psychiatric disorders.

The criminal justice system. Since the deinstitutionalization era, persons with mental illness have reappeared in U.S. jails (Geller, 2000; Jemelka, Trupin, & Chiles, 1989; Teplin, 1990; Teplin, Abram, & McClelland, 1996; Torrey, 1997). Recent statistics from the U.S. Department of Justice (1997-2000) estimate that 283,000 people who are incarcerated on any given day in the United States have a mental illness. The rate of mental illness in the jailed population is 4 times greater than that in the general population, and jails are de facto mental health services settings for those with mental illness (McNiel, Binder, & Robinson, 2005).

Despite a decrease in older adults' arrest rates, the number of elders in prisons in the United States has risen dramatically, with more than 125,000 prisoners older than 50 years and 35,000 prisoners older than 65 years in correctional facilities in the United States (Taylor & Wertel, 2004). The Federal Bureau of Prisons estimated that in 2006, 16% of the prison population would be aged 50 years or older (Morton, 1992), a proportion projected to increase to 33% by 2030 because of sentencing laws and demographic shifts. This shift entails substantial cost burdens—incarceration of an older adult inmate costs approximately \$69,000 per year, in contrast to \$27,000 per year for a younger adult—and new demands for the provision of health care (Anno, Graham, Lawrence, & Shansky, 2004; Schreiber, 1999). Of most concern from the perspective of GPN practice is that the majority of incarceration settings have

limited resources for the treatment of mental illness and the care of aging inmates (Arndt, Turvey, & Flaum, 2002).

Few descriptions exist in the U.S. literature of GPN practice in prisons. One article commented on the demographic changes in the prison system and the plight of the aging prisoner, identifying violence as a major stressor for this inmate group, along with the need for improved depression recognition and treatment services (Smyer, Gragert, & LaMere, 1997). A second article critiqued the "revolving door" status of the prison system and recommended mandatory discharge medication and follow-up treatment for ex-inmates with mental illnesses to lower recidivism rates (Lee, Connolly, & Dietz, 2005). Although the need is clear, it is difficult to determine the numbers of nurses with specialist preparation in either geriatric or psychiatric nursing who work within the prison system.

Homeless shelters. In the 1980s, outreach services to homeless people with mental illness were identified as a necessary and unique component of the continuum of care for this growing population (Lam & Rosenheck, 1999). Over the past decade, mental health programs have expanded their outreach to people with mental illness to include jailed populations and persons moving between the criminal justice system and the streets (Rock, 2001). The situation of U.S. veterans in the prison system and on the streets is of particular concern, with that population known to be older and more likely to have complex health issues including substance abuse and posttraumatic stress disorder (David, Woodward, Esquenazi, & Mellman, 2004; Gamache, Rosenheck, & Tessler, 2000; McGuire, Rosenheck, & Kaspro, 2003).

An extensive literature describes both established and innovative programs designed to combat homelessness in the United States. The Web page of the National Resource and Training Center on Homelessness and Mental Illness (2005) is an excellent resource. Although many programs focus on persons with co-occurring mental disorders, particularly substance abuse, there is inadequate focus on older adults with mental illness as a subgroup of the homeless (U.S. Bureau of Primary Health Care, 2003). Nurses are involved in staffing innovative practice programs focused on older homeless persons but have not reported their experiences or accomplishments in mainstream nursing literature; rather, practice contributions from nursing often are embedded within multidisciplinary program reports

and in reports from nontraditional care providers. In support of nurses' involvement, figures from the Health Care for the Homeless Clinicians' Network, the only formal group of its kind in the United States, show that nurses and nurse practitioners account for 37% of the membership of the group, with the next largest discipline being physicians at 17%. Nursing profiles on the Web site speak to the compassion and skill of those working with the mentally ill and homeless and the recognition that practice models are important:

My particular passion is addressing the complex needs of homeless people who have severe, persistent mental illness, particularly those who do not self-identify as such. I believe services can be "packaged" and delivered in an acceptable and accessible manner. Ideally, we need a good model of delivery along with the right people providing care. If I could have only one of those, however, I would choose having the right people. The right people will make it work. You can have a great model, but without the right people, nothing will get done. (Nickerson, MSN, ANP, RN, winner of the 2000 Outstanding Service Award, Health Care for the Homeless Clinicians' Network; see National Healthcare for the Homeless Council, 2000)

Damrosch and Strasser (1988) noted the plight of homeless mentally ill elders and identified the need for team approaches to care management in this vulnerable group. Bissonnette and Hijazi (1994) described the Elders Living at Home Program, which has operated in Boston since 1986. It provides case management services and transitional housing assistance (temporary and emergency) to more than 2,500 homeless and at-risk elders aged 55 years and older. Of 169 individuals who left the program in 2002, 74% moved on to the appropriate next-step placement, such as permanent housing, a transitional program, or reunification with family. The authors did not report, however, what proportion of their clients had a mental illness and required specialized care. On-site, shelter-based care is a practice model that meets the clients where they are, an advantage for elders with limited options (Sochalski & Mark, 2001).

Homelessness can impair mental functioning, regardless of a person's age, gender, race, or medical and psychological history. Given the greater disease burden of homeless elders and the need for specific and targeted outreach to connect them to appropriate services (Garibaldi, Conde-Martel, & O'Toole, 2005), nursing must be a part of the discussion on how to strengthen programs and improve barriers to care for

those on the streets (see, for example, National Healthcare for the Homeless Council, 2005). Arguably, every nurse working with homeless persons needs fundamental skills specific to geropsychiatric practice, specifically the ability to recognize and report psychiatric symptoms and age-related problems. It is especially critical to reach nurses who work on the fringes of traditional practice, with the most vulnerable homeless and the incarcerated, and to value their practice and their insights.

SNAPSHOT OF TODAY'S GEROPSYCHIATRIC NURSES

In an effort to capture a snapshot of nurses working in geropsychiatric practices today, we queried members of the American Psychiatric Nurses Association Geropsychiatric Nursing Council on their online Web site. Questions posed were as follows: What are the components of your practice? What do you do? What things impact your practice? And What is your educational and experiential preparation for your GPN role? Five nurses responded from a membership of 52. The respondents all lived in the Midwest and were female, between 42 and 57 years of age, and prepared at the master's level (2 as psychiatric nurse practitioners, 2 as CNSs, and 1 as MEd). Each worked in a different type of clinical setting, including a geriatric outreach program, community mental health center, private practice, and hospital-based geropsychiatric units. Respondents described a range of psychiatric nursing experiences prior to working as geropsychiatric nurses, from critical care to inpatient psychiatry to medical/surgical nursing. Of the 4 who were advanced practice registered nurses, time since completion of the MS ranged from 2 to 22 years. The respondents' role components included direct patient care, care coordination, staff education, family care, and administrative activities such as report writing. The majority of time was spent in direct patient care and staff/family education. Two respondents precepted graduate nursing students. Barriers to practice included the lack of acceptance of the advanced practice registered nurse role by physicians and primary care providers, restrictive prescribing and/or licensing and credentialing laws, poor reimbursement and low salary, lack of education about the mental and physical causes of behavioral problems by the NH staff, general lack of staff education, and the stigma of mental illness, which limits referrals and adherence to treatment plans by both providers and patients. Peer and staff support and liberal advanced

practice registered nurse state practice acts had a positive impact on practice.

PRACTICE COMMENTARIES

The 4 advanced practice registered nurse practice exemplars, summarized here and provided unabridged online, reflect current pathways to preparation for GPN practice, clinical experiences, and challenges of self-identified geropsychiatric nurses. These solicited commentaries offer compelling insights into the reasons nurses choose this path, how they have found a practice niche, and what their practice entails.

Laura M. Struble, PhD, RN, GNP, came to GPN via neurointensive care and medical-surgical nursing, having had an enduring interest in caring for older adults. As a geriatric nurse practitioner in a neuropsychiatric consultation practice, she practices in an NH and provides direct patient care, care coordination, behavioral management consultation, and staff and family education. She describes the challenges to her practice as administrative policies, staff communication and education, and relationships with physicians.

Lynette M. Gisel, MSN, GNP, developed a passion for the care of older adults at an early age and recognized the need for better mental health care for older adults after working as a nurse in critical care and a dementia unit. She returned to school for an MS in geriatric mental health and then received a post-master's certificate as a geriatric nurse practitioner. In her current position as a geriatric nurse practitioner in a hospital-based outpatient clinic and long-term care facilities, she provides direct patient care including prescribing medications and laboratory tests, consults in treatment planning, and provides care coordination and family education. The biggest challenges to her practice are administrative and federal policies that restrict her psychopharmacology practice.

Maria Cofrancesco, MS, RN, CNP, CNS, started her career in administration, then moved to home care and hospice nursing. After completing an MS nursing program as a geriatric nurse practitioner and working for a few years, she realized the need for specialized education in GPN. She completed a post-master's certificate program in psychiatric/mental health nursing with a clinical focus on adults and older adults. As a geriatric nurse practitioner and psychiatric/mental health CNS, she provides direct patient care to older adults in long-term care facilities, including NHs and assisted living centers, and offers psychiatric consultation to other geriatric nurse practitioners in the company. Because of her dual certification and roles,

Ms. Cofrancesco finds meeting the demands of both roles one of her biggest challenges. Colleague and staff communication is also challenging.

Susan M. Sawyer-DeMaris, MSN, CNS, came to her position as a geropsychiatric nurse through preparation and certification as an adult psychiatric/mental health CNS. Although she received no formal educational preparation in geriatric nursing or GPN, she accepted a position as psychiatric/mental health CNS in a 500-bed NH in 1989 and has been practicing there since. Her love of GPN has evolved over 16 years through her contact with residents, staff, and colleagues. Ms. Sawyer-DeMaris's job entails direct patient care including prescriptive practice, psychotherapy, behavioral management, staff consultation and education, family education, and facility committee leadership. She describes her biggest practice challenge as the lack of a road map for her advanced practice role in NHs and the lack of respect for her role during her early years of employment in the NH. Current challenges include the lack of community residential resources for older adults who need active psychiatric treatment and the state and federal laws that regulate her psychopharmacology practice.

Although each of these nurses came to GPN educationally prepared in different ways and each has a different job, their practices look similar and have similar challenges. It is interesting to note that many of the geropsychiatric nurses identified positive staff and colleague relationships as the most rewarding aspect of their practices. The full online commentaries provide an insider's view of the day-to-day activities and challenges experienced by a variety of geriatric nurse practitioners in the United States. It is important to understand these as we chart the direction for the future of GPN practice.

CHALLENGES AND OPPORTUNITIES

Geropsychiatric nurses today face the challenges of being visible, visionary, and effective mental health care providers to a growing population of older adults with increasing mental health needs. Mental health services for elders encompass a wide range of models. This literature review and our informal survey identified diverse yet common practice models for GPN in inpatient, outpatient, and nontraditional settings. Work settings and roles include psychiatric consultation-liaison in NHs and hospitals, psychiatric nurses in home care, geriatric nurse practitioners in long-term care, community case/care managers, and consultation and leadership on multidisciplinary teams. Other geropsychiatric care is provided by staff nurses in

long-term care facilities, inpatient psychiatric units, consumers' homes, and incarceration settings, as well as on the streets. There are few if any models developed by nurses for the elderly populations who reside in ALFs, special dementia care units, state hospitals, prisons, and homeless shelters. In addition, most older adults receive their mental health care from primary care providers, and there are few reported nursing-centered models for providing mental health care in primary care settings. Although there are a few effective practice models used in traditional contexts of care, some of which are theoretically based and acceptable to consumers and professionals, to date the literature is more descriptive of practice models than suggestive of efficacy. Sherrill (2001) suggested that as a "marginal" specialty, GPN should exploit the uniqueness of that position and develop new models of mental health care outside the traditional contexts of practice. Because geropsychiatric nurses practice in the overlapping spaces of two specialties, we can use the knowledge and skills of both (and others) to our advantage. We must be able to articulate, describe, and evaluate our practice across multiple contexts and bring this practice knowledge to inform the policy debate on the types and quality of services older adults with mental illness in the United States require and deserve. Who knows what we do? Most important, why is it critical that we exist, and what, if anything, is unique about our practice? We must also be able to speak to those who have recently chosen nursing to excite and engage young nurses to commit to GPN practice.

RECOMMENDATIONS

1. Identify the status of current GPN practice in the United States.
 - 1.1 Commission a national survey of colleagues who identify themselves as geropsychiatric nurses and describe their preparation and scope of practice.
 - 1.2 Seek consumer commentaries on our practice: Do we provide a service that consumers need? Are they satisfied with our care?
 - 1.3 Seek professional commentaries on our practice: What service do we provide that is not provided by others?
 - 1.4 Develop a national database of geropsychiatric nurses.
 - 1.5 Translate the effectiveness of our practice for the public.
2. Promote the role of the GPN specialist as a vital member of the multidisciplinary care team in aging.

- 2.1 Provide GPN booths at major aging and psychiatric conferences that span the disciplines involved in health care of the aged.
- 2.2 Seek funding to enhance the profile of geropsychiatric practice in U.S. colleges of nursing.
- 2.3 Lobby relevant bodies (e.g., Congress, state legislatures) about the demographic imperative. Prepare a small group of articulate, informed, and passionate GPN lobbyists who act as spokespersons.
3. Reward excellence in, and visibility of, GPN practice within the United States and globally.
 - 3.1 Convene international conferences with competitive practice awards highlighted on Web sites and journals.
 - 3.2 Publish special editions of professional journals, highlighting GPN practice models and research.
4. Support the development of innovative practice models that target underserved populations in both traditional and nontraditional settings.
 - 4.1 Partner with nursing and other professional colleagues to provide outreach, assessment, and treatment of mental illness to elders in settings such as churches, prisons, homeless shelters, and other residential settings.
 - 4.2 Partner with nursing and other professional colleagues in traditional practice settings to provide professional education and outreach to consumers and families, including subgroups of ethnic minority older adults, persons with chronic mental illnesses, and those at high risk for mental illness because of coexisting medical illnesses.
 - 4.3 Develop methods for testing and translating GPN practice for application to broader populations.
5. Generate core competencies essential for geropsychiatric practice at the generalist, master's, and doctoral practice levels.
 - 5.1 Collaborate with professional practice and credentialing organizations to ensure that geropsychiatric content is taught in educational programs and competencies are tested in certifying exams.
6. Seek a national certification process for specialists in GPN practice.
7. Educate and support nurses entering the profession about careers in geropsychiatric practice.
 - 7.1 Offer competitive scholarships to excellent schools for specific geropsychiatric practice training such as an extension of current Hartford initiatives.
 - 7.2 Create a 1-year mentoring program in geropsychiatric practice, matching new master's-prepared graduates with seasoned geropsychiatric practitioners.

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