Published in final edited form as:

Arch Psychiatr Nurs. 1994 August ; 8(4): 272–279.

Geropsychiatric Nursing Consultation: A Valuable Resource in Rural Long-Term Care

Marianne Smith, Susan Mitchell, Kathleen C. Buckwalter, Linda Garand

Abbe Center for Community Mental Health, Cedar Rapids; and the Office of Consultation and Research in Medical Education, University of Iowa. Iowa City, IA

Abstract

Psychiatric and geropsychiatric nurse specialists have the potential to positively influence the day-to-day care provided in rural nursing homes by acting as teachers, resource persons, facilitators, and role models to long-term care (LTC) personnel. The combined approach of training LTC nurses to train their own staff while supporting the application of learning with consultee-focused nursing consultation proved to be an effective and time-efficient method of improving the geropsychiatric nursing care provided in rural nursing homes.

AS MANY AS 75% of all residents in long-term care (LTC) settings suffer from some sort of mental disorder (Bums, 1985; Rovner & Rabins, 1985; Roybal, 1984), with depression and dementia being the two most common disorders. In fact, the prevalence of mental illness and behavioral disorders has led some to describe today's nursing homes as "modern psychiatric ghettos" for the elderly (Liptzin, 1986; Moss & Halaman-dariz, 1977). Unfortunately, the behavioral problems associated with mental illness, or threats to mental health, are typically not well understood, tolerated, or effectively managed by staff in long-term care (LTC) settings. In too many cases, mental problems are "written off" as a normal and unavoidable part of growing old (Harper, 1986), perceived as unnecessary and controllable behavior that is manipulative and attention-seeking (McLeod & Schwartz, 1992), or viewed as a problem that is not the responsibility of the LTC staff, but as a psychiatric problem that demands a psychiatrist's attention.

Although many LTC residents may benefit from the services of a psychiatrist or other mental health professional, such assistance is often difficult to access, particularly in rural areas. Sparsely populated and geographically remote communities increasingly struggle to maintain adequate general health care services for individuals of all ages, let alone specialized services such as psychiatry and geriatrics. This article provides a brief overview of the challenges confronting rural LTC facilities and describes a model of service delivery in which geropsychiatric nurses may indirectly exert a positive influence on the day-to-day mental health nursing care provided in geographically remote facilities. The merits of consultee-focused geropsychiatric nursing consultation as a vehicle for moving classroom learning into care practice routines is illustrated with case vignettes.

CHALLENGES CONFRONTING RURAL FACILITIES

In addition to the difficulties encountered by their urban counterparts (e.g., inadequate reimbursement rates, staff turnover, demands of caring for sicker and more dependent residents), many rural nursing homes face additional challenges that impinge on the quality of mental health care they may provide. Although a variety of socioeconomic, economic, and cultural issues are influential, three primary barriers to accessing mental health services are discussed briefly here: the lack of qualified mental health professionals, lack of cooperation between aging and mental health service delivery systems, and geographic distance to services.

Lack of Professionals

The overall lack of trained mental health professionals in rural communities is a matter that affects both the availability of services and the quality of care provided to rural elderly. The scarcity of human resources in rural settings often demands triage of patients based on their rehabilitative potential: children and adolescents typically receive psychotherapy whereas adults are treated with crisis intervention and brief therapies (Buckwalter, Smith, & Caston, 1994). Many rural community mental health centers do not provide any type of specialized service to older adults and only marginally serve elderly via traditional services (Weber, 1990). Services provided on site in nursing homes, although clearly beneficial to residents and staff alike (Boorson, Liptzin, Nininger, & Rabins, 1987; Rabins, Storer, & Lawrence, 1992), are typically impractical in rural settings where the volume of professional time spent traveling must be considered in terms of cost-effectiveness of service delivery.

Even when psychiatric nurses and social workers are available to provide mental health services to the elderly, the dearth of psychiatrists in rural communities often obstructs third party reimbursement. Coupled with lower Medicare reimbursement to physicians and rural health clinics as compared with urban ones (Patton, 1989), the lack of professional mental health services provided to rural LTC facilities is an understandable response. Unfortunately, the list of reality-based disincentives to develop and provide professional services to rural nursing homes usually overwhelms even motivated mental health providers.

Aging Versus Mental Health Systems

The lack of appropriate mental health services for aging individuals in rural communities is further aggravated by the question of ownership of aging individuals' problems. Mental health providers, many of whom are necessarily focused on their own survival, tend to view the mental health problems of older adults as the domain of the aging service system. Their observation that "elderly won't use mental health services" is too often used as a justification for not providing appropriate services (Rathbone-McCuan, 1992), rather than as an incentive to develop creative, cooperative ventures between aging and mental health agencies.

At the same time, area agencies on aging (AAAs) distance themselves from the mental health care problems of the elderly, fearing that such an alliance would draw them into the "realm of politically charged and stigmatized psychiatric care" (Rathbone-McCuan, 1992, p.

88) and thus reduce the effectiveness of other programs they support (e.g., outreach, home health, day care, health assessments). These conditions reduce the likelihood that service delivery systems will be developed and may, in fact, impede creative solutions needed to serve rural elderly (Rathbone-McCuan, 1992).

Geographic Distance

A third issue unique to rural LTC facilities is the geographical distance to access health and mental health services, a matter that is becoming increasingly acute in rural America. The financial crises facing many rural hospitals and health centers, where rural elderly traditionally receive their mental health care, have resulted in fewer providers and greater distances to receive services (Beaulieu, 1992). The long distance to services is frequently compounded by bad weather, lack of public transportation, and inadequate road conditions (Coward & Cutler, 1989), which further reduces the likelihood that frail elderly nursing home residents will receive services.

Thus, observed and projected deficits in mental health care may be most acutely felt in rural nursing homes. Facilities in remote rural areas, no matter how well intentioned, often struggle to find appropriate evaluation, treatment, and supportive services for their mentally ill residents. Likewise, even the most motivated and caring mental health provider is challenged to provide needed assistance in light of the current climate of care. As a result, creative, collaborative, practical approaches are needed to counteract the deficit of ongoing, on-site assistance to nursing home residents and personnel by qualified mental health professionals.

Geropsychiatric and psychiatric nurses may positively influence the day-to-day mental health care provided in even the most rural LTC facilities by using technology, training, and consultee-centered consultation. By improving the knowledge and skills of the frontline staff, many behavior management problems may be avoided or minimized. Thus, the demand for outside professional assistance may be reduced while the therapeutic climate and quality of care provided to residents within the facility is improved.

PROJECT OVERVIEW

The strategies described here were implemented and evaluated as part of a statewide geriatric mental health training project designed to increase the ability of nurses and nursing personnel in rural LTC facilities to provide quality mental health nursing care to their residents with psychiatric and behavioral problems. The 3-year, three phase project used a train-the-trainer model combined with consultee-centered nursing consultation in the effort to improve patient care.

The dual approach of providing concrete information (via training) while supporting, assisting, and encouraging nursing leadership in the development and implementation of mental health interventions within the LTC facility (via consultation) was found to be an effective strategy for improving the quality of care provided in rural facilities. Importantly, both foci used indirect methods of changing the attitudes, beliefs, and behaviors of nursing personnel. That is, geropsychiatric clinical nurse specialists (OSCNS) sought to change

mental health care practices while minimizing their physical presence in the facilities. Instead of providing on-site training or patient assessment services, which are accompanied by all of the inherent difficulties described in the previous section, assistance was provided indirectly. By using telephone and telecommunication systems to train trainers and providing nursing consultation that focused on the problems, perceptions, and experiences of the nurse consultee (thus avoiding the need to travel to evaluate patients), project staff were able to provide highly specialized assistance to a large number of geographically remote facilities. The two main thrusts, training trainers and consultee-centered geropsychiatric nursing consultation, are described briefly in the following paragraphs.

TRAIN-THE-TRAINER MODEL

The train-the-trainer approach was used to overcome problems associated with limited professional time and geographic distance. In this project 200 registered nurses and directors of nursing representing 99 LTC facilities were trained in three separate 2-day Intensive Training Sessions (ITS) conducted by project staff. Training was provided in person during the first phase of training (provided locally) and via two-way interactive telecommunication systems in the second and third phases (regional and statewide training respectively). As part of the ITS, LTC nurses were provided detailed program materials on six separate topics (i.e., overview of behavioral problems and staff roles, communication issues, acting out and aggressive behavior, depression, dementia, control and power issues). In turn, these LTC nurses were asked to teach six in-service education programs for additional staff in their own facilities using the program materials provided at the ITS. Thus, the investment of 48 hours of training conducted by OPCNSs resulted in the provision of over 450 hours of in-service education on mental health topics that reached over 1,600 nursing personnel across the state.

The most obvious benefit of the approach was the ability to reach facilities that would otherwise be geographically inaccessible to the project staff. Likewise, the pyramid effect created by training trainers resulted in large numbers of staff being trained with only a modest investment of training time on the part of the OPCNSs. Training time discussed here addresses only the time spent actually training LTC nurses. In this project, additional time (6 months to develop six program modules and the ITS format) was spent developing program materials for the nurse trainers to use as they trained their own staff.

Project staff also viewed training trainers as a means to nurture new roles among the LTC nurse trainers. That is, LTC nurse trainers were encouraged to act as resource persons, facilitators, advocates, and leaders in the implementation of mental health nursing interventions in their respective facilities. The importance of these additional roles was reinforced during the ITS, promoted within the program materials, and encouraged via the consultation process.

For example, each module contained instructors' notes that recommended specific activities to personalize the program content to that facility's resident population and staff, such as searching out real-life care challenges and actually trying recommended interventions before teaching the program, to improve illustration. Notes within the lecturer's script cued the nurse trainer to stop, discuss, illustrate and/or role-play with staff. As liaison to the

geropsychiatric nurse specialist, the nurse trainer was placed in a position of authority in terms of initiating requests for additional outside assistance to resolve or reduce behavior management problems and communicating the information gained with staff. In short, every effort was made to enhance the image of the LTC nurse trainer, and her staff, as capable providers of basic geriatric mental health nursing care.

CONSUL TEE-CENTER CONSULTATION

The provision of consultee-centered (Caplan, 1970) geropsychiatric nursing consultation as an adjunct to training was considered of paramount importance in this project. That is, the consultee's perception of the problem, whether regarding resident care or execution of the training programs, was the focus of the nursing consultation. In contrast to a client-centered model, in which the consultant directly evaluates residents, provides therapy, and/or makes treatment recommendations, consultants engaged consultees in a process of description, discussion, and problem-solving that placed them in a position of authority about the nature of the problem and possible methods to resolve it. Thus, the GPCNS consultant acted as a facilitator, information source, teacher, and role model to the LTC nurse trainer and her staff. Consultation was provided primarily by telephone with occasional on-site visits made as needed. Over the 3-year project, 17 on-site consultations and 127 telephone contacts were made. The following case descriptions illustrate how training and consultation were combined to enhance day-to-day mental health nursing care practices.

Case 1: Mrs. Green

"Staff are at the end of their coping rope," noted the nurse trainer from the nursing home, "This resident is driving us all crazy." The complaint, a common one among LTC providers, was followed by the observation that the facility was considering discharge because of their lack of ability to manage the resident's "manipulative, back-stabbing, and sexually inappropriate behaviors."

The initial telephone conversation showed that the resident, Mrs. Green, was admitted to the facility 4 months earlier because of urological difficulties that required intermittent catheterization. Although a long list of physical maladies were noted in her history, she was taking minimal medication (antibiotics, vitamins, and stool softeners) and was described by staff as being ambulatory and capable of self-care activities. Mrs. Green was described by her physician as mildly depressed following the death of her husband 6 months ago but had no other psychiatric diagnosis recorded in her chart. However, family history showed that she was estranged from her daughter June who described her mother as demanding, overly dependent, and "always sick" although June suspected that much of the illness was "in her [mother's] head." When contacted by the facility for guidance regarding Mrs. Green's behavior, June responded that the manipulative, overly dependent, helpless, and back-stabbing behavior was typical of her mother. June reported having little contact with her mother since going to college, "to maintain her own mental health," and predicted that nothing would probably change her mother's behavior.

The LTC nurse trainer asked that the GPCNS assess and treat the resident and provide nursing care recommendations to staff, a request that was in keeping with the client-centered

nursing consultation provided before the current project. Instead, the consultant asked the LTC nurse trainer to first do the following things; (1) verify the absence of psychiatric history with Mrs. Green, June, and the attending primary care physician; (2) assess the resident's cognitive status using the Mini Mental State Exam (described in the dementia module and taught at the ITS) to rule out an organic cause for the perceived manipulative behavior; (3) teach the program "Acting Up and Acting Out; Assessing and Managing Aggressive and Acting Out Behaviors" (which was part of the training series) to staff who were most effected by Mrs. Green's behavior, applying the program concepts to Mrs. Green during the in-service program; and then (4) convene a nursing consultation meeting to discuss and plan Mrs. Green's care.

The "Acting Up and Acting Out" in-service program introduced staff to the antecedent-behavior-consequence (ABC) approach to behavior management. Thus, nursing personnel were challenged to think about Mrs. Green's problem behaviors individually and to consider both antecedents and consequences that might be changed. Staff were asked to write down specific information on the program handouts regarding Mrs. Green and then to bring that information with them to the nursing consultation meeting. The focus of the consultation, then, was to assist staff to (1) prioritize problems; (2) brainstorm about possible changes in nursing care practice to reduce negative behaviors; (3) develop a specific care plan; (4) anticipate the resident's reaction to and possible resistance of this plan of care; and (5) role-play possible staff responses to behavior that was upsetting and frustrating.

Although staff were anxious to have the GPCNS consultant meet and assess Mrs. Green so that she could really understand what they had been going through, the consultant deferred, saying "What I think of the resident really isn't as important as what *you* think about the resident. You know the resident much better than I will after a brief visit. Even if I spend an hour a week with Mrs. Green, you'll still have to spend 24 hours a day, 7 days a week managing her care. So tell me what you know about her, what happens here that upsets you, and what you've already tried. And then let's think about how *you* might do things differently, or just think differently about Mrs. Green, to get along better." Although initially puzzled by this approach, staff soon warmed to the idea that their understanding of the problem was the consultant's primary concern.

Using the ABC concepts and handouts, the GPCNS facilitated discussion and problem-solving by questioning, redirecting, and challenging staff to explore Mrs. Green's behavior (historically and currently) and to examine their own feelings and reactions to her. The problem list, which was lengthy, was prioritized and issues of safety (smoking in her room) and infringement of other residents' rights (public nudity) were targeted for immediate interventions. The process of setting limits in these two areas, including the development of reasonable and practical consequences when the behavior occurred, was discussed, role-played, and recorded in the care plan. Staff responsibilities, in terms of patient care and communication with other nursing personnel, family, visitors and administration, were established to improve consistency and continuity of care. A time frame for evaluation of the care plan was decided on including a follow-up staff planning meeting. After much discussion, staff concluded that they needed more accurate information about Mrs. Green's real-life abilities and limitations to guide their thinking and care practices. As a result, they

decided to request a comprehensive work-up at the nearby university-based geriatric assessment clinic.

The consultation visit, which lasted 90 minutes, focused exclusively on the staffs' knowledge, understanding, and perception of the identified resident. The consultant, who came into the meeting cold, (i.e., without having assessed the patient or read the chart) relied entirely on the staffs' observations, experiences, and knowledge of the resident. The earlier request for the nurse trainer to search out psychiatric history and possible organicity (both of which were negative), combined with information accumulated during the in-service program, provided staff and the consultant with a solid base of information from which to work. By acting as a facilitator, resource person, and role-model, the GPCNS championed the staffs' ability to understand and manage the problem behaviors Mrs. Green exhibited. The resulting plan of action relied on the skill, ability, and commitment of direct service staff rather than on interventions provided periodically by a mental health professional. Although the GPCNS provided intermittent telephone consultation regarding Mrs. Green's progress and additional interventions, no further on-site visits were needed to sustain and expand the plan of care. Over a 6-month period of time, the nurse trainer reported that Mrs. Green and the staff came to an understanding of acceptable and unacceptable behaviors. Mrs. Green abandoned many of the attention-seeking behaviors that previously upset and frustrated staff. Simultaneously, staff exhibited increased tolerance, caring, and compassion toward Mrs. Green and other so-called manipulative residents.

Case 2: Mr. Brown

"He's so restless and confused. Half of the time staff are afraid *for* him, and the other half of the time they're afraid *of* him!" noted the nurse trainer. "We don't know where to begin!" The request for assistance came long distance from a nurse trained during the telecommunication program provided to facilities across the state in the third year of the project. Because the facility was over 3 hours away, making an on-site visit impractical, the nurse trainer and consultant explored the resident's behavior, staff reactions, and possible solutions over the telephone.

The initial telephone consultation showed that the resident, Mr. Brown, was a spry 75-year-old who was described as very agitated and restless, persistently wanting to "visit his father" or "go home," and wandering throughout the building and sometimes outside as he attempted to escape "these jailors" (staff) who had "locked him up." He had a diagnosis of "probable Alzheimer's Dis-ease" after a comprehensive work-up nearly 3 years earlier. Before his admission a month ago, Mr. Brown lived alone in his long-time family home with minimal supervision by his neighbor and had no family nearby. Recent safety issues necessitated admission to the small rural nursing home.

Although the two educational programs most relevant to this resident (i.e., on dementia and assessing and managing aggressive and acting out behavior) had been taught earlier, the consultant suggested that the nurse trainer offer a special re-fresher course focusing specifically on Mr. Brown's care plan. To assist the nurse trainer in conducting this session, the consultant offered the following suggestions: (1) review both programs in depth, thinking only about Mr. Brown, his history, long-standing behavior, current behavior, and

possible antecedents and consequences that might be influential in his presentation; (2) photocopy specific handouts to use as worksheets during the program (i.e., “Assessment: Checking It Out”; “Interventions: Management & Care Planning” (in dementia); “Interventions: Reality vs. Validation”; and “Interventions: Managing Delusions & Hallucinations”); (3) talk to staff and make a preliminary problem list for Mr. Brown; and (4) invite key staff from all three shifts to participate in the special session.

Before the meeting, the consultant and nurse trainer visited by telephone to review the information. The telephone consultation (which lasted 60 minutes) focused on the nurse trainer’s perception of Mr. Brown, the staff, and the proposed care planning session. The consultant clarified and expanded on the nurse trainer’s understanding of the program concepts as needed and offered additional suggestions, illustrations, and anticipatory guidance about process-oriented matters. The importance of clarifying, rephrasing, redirecting, focusing, and listening (taught during the ITS) were again reviewed. Finally, the nurse trainer was asked to predict potential pitfalls in the proposed refresher course/care planning session. In response, the nurse trainer expressed concern about staff reactions to the use of validation principles (Feil, 1982).

Although enthusiastic about the use of validation herself, the nurse trainer (who also happened to be the director of nursing) anticipated that use of this approach with Mr. Brown would be a “hot” topic among staff. During the dementia program (which recommends validation to reduce “you’re wrong” messages in the environment and thus increases comfort), some staff expressed resistance saying that it “was lying to the resident” and that they didn’t “approve.” As a result, the conversation turned to the nurse trainer’s dual role as the geriatric mental health trainer (e.g., role model, facilitator, advocate, and leader in planning and executing mental health care plans) and director of nursing (e.g., policy-setter, supervisor, facilitator, and potential disciplinarian of staff). Possible responses to staff questions, concerns, or conflicts within the work group and after the meeting were explored, focusing on methods to increase compliance and reduce resistance.

A very brief third telephone consultation occurred approximately a month later when the nurse trainer called to report the staffs’ new success in managing Mr. Brown. The nurse trainer reported that the refresher course/care planning meeting, although heated at times, resulted in improved communication and cooperation between staff, and consensus on care strategies for Mr. Brown. By manipulating both the physical and personal environment, including the use of validation to reduce Mr. Brown’s frustration, staff had been successful in increasing both his and their comfort level. No further assistance was required.

Consultation Survey Results

In addition to anecdotal notes maintained by GPCNSs, the value of nursing consultation was also supported by results of a survey conducted as part of the overall evaluation (Smith, Mitchell, Buckwalter, & Garand, 1994). Surveys were returned by 63% of the evaluation facilities (N = 57). In brief, nearly all respondents agreed that the consultant understood their problem well (86%), offered them realistic solutions (81 %), and that they valued the consultation overall (97%). The majority observed that the consultation helped staff

understand the resident and/or manage the difficult behavior (95%). All agreed that they would use the service again.

DISCUSSION AND SUMMARY

The need for mental health professionals to assess and treat mentally ill residents in rural nursing homes is a current challenge that will only increase with the passage of time.

Although the combined approach of training and consultee-centered nursing consultation cannot completely ameliorate the need for direct professional interventions, this service-delivery approach may reduce the demand for assistance with behavioral problems that nursing home staff may effectively manage themselves.

Several factors are believed to be critical to the successful implementation of such a model. First, LTC staff must receive sound geriatric mental health training that focuses on the practical aspects of mental health assessment and intervention. Programs must be written in understandable language that nursing assistants can easily understand, avoiding common psychiatric jargon, and focusing on the real-life concerns of the staff. Second, the psychiatric nurse specialist must aggressively advertise the availability of consultation services, explaining nursing consultation in general and consultee-centered consultation in specific, to maximize the benefits of these services to clients. Third, clear criteria are needed to determine when consultee-focused consultation is, in fact, the most effective approach to resolving the problem. In this model, OPCNS consultants required that consultees had taught (or plan to teach) the six core geriatric mental health training programs; had reviewed the chart and talked with staff to determine possible causes (psychiatric or physical) of the observed problem behavior; and were willing to have the resident assessed by a mental health professional if a diagnostic evaluation and/or professional interventions were needed. Finally, the model relies almost exclusively on the motivation of the LTC facility staff and particularly on nursing leaders within those facilities. Without the clear commitment of nurse trainers in this project, little could have been accomplished.

In conclusion, the dual approach of providing necessary information via training and promoting the application of that knowledge through consultee-centered consultation may be an effective strategy for changing day-to-day mental health nursing interventions in rural LTC facilities. The use of telecommunication systems to train trainers supplemented by telephone consultation and limited on-site assistance increases the ability of nurse specialists to reach larger numbers of nursing personnel, including those in geographically remote rural areas. Most importantly, perhaps, the approach supports and champions the LTC nursing staffs' ability to understand, assess, problem-solve, and manage various types of difficult behavior internally. Thus, psychiatric specialists may indirectly improve the quality of resident care and quality of work life for LTC staff by acting as teachers, facilitators, and resource persons both in person and long distance.

Acknowledgments

Supported by grant No. D10NU27118-01, Division of Nursing, Bureau of Health Professions.

REFERENCES

- Beaulieu B (1992). Small rural hospitals with long-term care: 1983–1987. *Journal of Rural Health*, 8(2), 121–142. [PubMed: 10119762]
- Boorson S, Liptzin B, Nininger J, & Rabins P (1987). Psychiatry and the nursing home. *American Journal of Psychiatry*, 144, 1412–1418. [PubMed: 3314537]
- Buckwalter K, Smith M, & Caston C (1994). Mental and social health of rural elderly In Coward R, Bull N, Kukulka G, & Gallaher J (Eds.), *Health Services for Rural Elders*. New York: Springer.
- Burns B (1985, 12 3–4). The National Nursing Home Survey Paper presented at the National Institute of Mental Health Conference on The Chronically Mentally III Elderly. Orlando, FL.
- Caplan G (1970). *The theory and practice of mental health consultation*. New York: Basic Books.
- Coward R, & Cutler S (1989). Informal and formal health care systems for the rural elderly. *Health Services Research*, 23(6), 785–806. [PubMed: 2645248]
- Feil N (1982). *Validation-The Feil method: How to help disoriented old-old*. Cleveland, OH: Edward Feil Productions.
- Finkel S, & Denison M (1990). Psychopathology in later life. *Comprehensive Therapy*, 16(9), 17–24.
- Harper M (1986). Introduction. In Harper MS & Lie-bowitz B, *Mental illness in nursing homes: Agenda for research* National Institute of Mental Health, Washington, DC: U.S. Government Printing Office.
- Liprzin B (1986). Major Mental Disorders/Problems in Nursing Homes: Implications for Research and Public Policy In Harper M and Liebowitz B(Eds.), *Mental illness in nursing homes: Agenda for research*. National Institute of Mental Health, Washington, DC: U.S. Government Printing Office.
- McLeod E, & Schwartz F (1992). Working together: Collaboration among HCWs and families in long-term care. *Journal of Gerontological Nursing*, (18),26–30.
- Moss F, & Halamandaz V (1977). *Too old, too sick, too bad: Nursing homes in America*. Baltimore, MD: Aspen Systems Company.
- Patton L (1989). Setting the rural health services research agenda: The congressional perspective. *Health Services Research*, 23(6), 1005–1051. [PubMed: 2492981]
- Rabins P, Storer D, & Lawrence M (1992). Psychiatric consultation to a continuing care retirement community. *The Gerontologist*, 32(1), 126–128. [PubMed: 1740248]
- Rathbone-McCuan E (1992). Rural mental health service for the elderly: A discussion of short-range futures In Bull CN & Bane SD (Eds.), *The future of aging in rural American: Proceedings of a national symposium*. Kansas City, MO: National Resource Center for Rural Elderly.
- Roybal ER (1984). Federal involvement in mental health care for the aged. *American Psychologist*, 39(2), 163–166. [PubMed: 6703465]
- Rovner BW, & Rabins PY (1985). Mental illness among nursing home patients. *Hospital and Community Psychiatry*, 36(1), 119–128. [PubMed: 3972338]
- Smith M, Mitchell, Buckwalter K, & Garand L (1994). Geropsychiatric nursing consultation as an adjunct to training in long-term care facilities: The indirect approach. (Submitted).
- Weber S (1990, 3 15). The rural elderly networker National Resource Center for Rural Elderly: Kansas City, MO.