RELOCATION STRESS AND THE ELDERLY:

A REVIEW OF THE LITERATURE WITH

IMPLICATIONS FOR SOCIAL WORK PRACTICE

BY

G. SANDRA HANVEY

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MAJOR PAPER

SUBMITTED IN PARTIAL FULFILLMENT OF THE

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INTRODUCTION

Relocation of the elderly has been studied from the perspective of movement from one community setting to another; movement from the community to an institution; and movement both within and between institutions. There now exists an extensive body of research documenting the physical and psycho-social effect of relocation on the elderly. This research indicates that relocation almost always entails a significant and often stressful adjustment for the older person. Community to institution relocation appears to be a particularly stress-ful transition, and contains the potential for negative physical and psychological consequences.

The number of elderly who have experienced this community to institution transition is noteworthy. Although only a minority of the total population of elderly require or enter long-term institutional care, the number of institutionalized elderly is not inconsiderable. In British Columbia at the present time 22,454 older persons are receiving care within long-term care facilities which provide a continuum of services ranging from minimal supervision and assistance with the activ-ities of daily living, to extensive medical management and skilled nursing care. (Bayley, 1981) In the years ahead, the demand for these services is likely to increase as the

population 65-and-over in Canada is projected to increase by more than three-quarters by the end of this century; and undoubtedly the number of elderly within institutions will also increase proportionately. (Denton & Spencer, 1980)

Relocation from the community to an institution can be perceived as a process that begins with the decision that institutionalization is necessary or perhaps unavoidable; and ends several months after the individual has actually entered care. This relocation process has gained increasing significance through research which indicates that in some measure the stress associated with relocation can be alleviated, and adaptation to care facilitated if the relocatee receives skillful and sensitive assistance through this transition period.

The utility of relocation research lies in its capacity to inform and direct policy shapers, planners, administrators and practitioners who are directly concerned and involved with those elderly persons who are undergoing this difficult transition. This research-generated knowledge can be translated into specific policies, programs and services that will facilitate the process of relocation. The major focus of this paper relates to both these aspects: first, it will examine the relevant research on relocation stress and the elderly; and second, discuss some intervention strategies that may assist the elderly person in negotiating the significant transition from home to institution.

Part 1 of this paper will examine some of the considerable body of research that has studied the effect of reloca-

tion on the elderly in terms of physical and psychosocial consequences. Most commonly, researchers have measured the negative effects of relocation in terms of increased mortality rates. This paper will examine a number of these studies, discuss the research strategies employed, and review their findings. In addition, research has identified a number of individual or situational variables that may moderate or aggravate the negative effects of relocation. This paper will also examine a number of these conditioning variables in an attempt to explain variations in outcome following relocation.

Since the design of programs and services for any population group must reflect the characteristics and needs of the population served, the second part of this paper will briefly review some of the facts now known about the institutionalized aged. This will include current statistics on institutionalization rates, and the characteristics of institutional populations. With this background, the paper will examine the circumstances under which institutionalization appears to be an appropriate or even inevitable response to the health and/or social needs of an elderly person.

Part 3 will focus specifically on community to institution relocation, and the role of the social worker in the relocation process. It will outline some programs and services that might be provided for elderly relocatees and their families throughout the transition period from the time of initial application for institutional placement, until several months after entering care.

RELOCATION DEFINED

Hasselkaus (1978) defines relocation as: "the change in environment that takes place when an individual moves from one location to another." (p. 631) Research on relocation of the elderly has primarily focused on movement: 1) from one community setting to another; 2) from the community to an institution; 3) from one institution to another; and 4) intra-institutional moves i.e. from one room to another.

A number of researchers have stressed the processual nature of relocation. They have described the move as a sequence of stages or phases, beginning with the situational changes which precipitate the decision to move; and ending several months after relocation following a period of adjustment. (Yawney & Slover, 1973); (Sherwood et al, 1974); (Tobin & Lieberman, 1976); (Pope 1979).

Tobin and Lieberman (1976) have broken this sequence into four stages: 1) the phase of predecision; 2) the phase of anticipating relocation; 3) the phase of initial adjustment; and 4) the phase of adaptation which encompasses the first several months after the initial adjustment.

STRESS DEFINED:
An Examination of Physiological, Sociological, and Psychological Concepts of Stress.

The literature to be reviewed on relocation stress does not explicitly define the concept of stress. Implicit in

the literature however is the general assumption that stressful
life events, such as relocation, may play a role in the etiology
of various somatic and psychological disorders.

Birren, (1965) conducted a study of healthy elderly men
residing in the community, and examined their experiences
during a number of significant life changes associated with
aging, including the death of a significant other, retirement
and changes in residence. These life events were subsumed
under a variable titled "environmental loss". Birren found
that this variable, "environmental loss", showed a significant
relationship not only to morale, life satisfaction and adequacy
in social relationships; but also to physiological, cognitive
and psychomotor variables as well.(p. 108)

Briefly, this paper will review some of the relevant
literature on stress, examine a conceptual model of stress,
and from this model outline the major variables which appear
to determine the degree of stress or personal disruption which
an individual will experience during the process of relocation.

Examination of the literature on stress reveals that
definitions of the phenomena of stress are often ambiguous
and inconsistent. Some researchers define stress in terms of
the stimuli or stressors that lead to changes in the organism.
Other researchers limit the definition to the response or out-
come from such stimuli. In some cases, stress is defined as
the emotional state accompanying some significant personal or
social change. (Levine & Scotch, 1970)

For the purposes of this paper, we will accept the

broad definition used by Lazarus (1960), which states:
"It seems wise to use "stress" as a generic term for the whole
area of problems that include the stimuli producing stress
reactions, the reactions themselves, and the various inter-
vening processes. Thus we can speak of the field of stress
and mean the physiological, sociological and psychological
phenomena and their respective concepts." (p. 27)

Research has primarily focused on physiological,
sociological and psychological stress as three separate levels
of analysis, although a number of studies have tacitly recogniz-
ed the complex interdependence between these levels. In
reviewing some of the relevant literature on stress, this
paper will retain these somewhat arbitrary levels of analysis,
and briefly examine the conceptual framework employed at each
level.

A physiological concept of stress

At the physiological level, researchers have studied the
bodily changes that occur as an adaptive response to a stress-
producing situation, thereby providing the theoretical links
between life stress and somatic illness.

Hans Selye is one of the pioneer researchers in the field
of physiological stress. As early as 1925, Selye had observed
a non-specific bodily response to a number of disease entities
which he termed the "syndrome of just being sick". (Selye, 1956)
His later research was directed to this observation. Selye
defines stress as the "non-specific" response of the body
to any demand made upon it. This non-specific response he

termed the "general adaptation syndrom," which is activated by adrenal and pituitary stimulation mediated through the nervous system. This endocrine activation produces adaptive hormones to combat wear and tear in the body. Selye had delineated three stages in this response syndrome which may take place under conditions of prolonged stress: 1) an initial stage of alarm, which activates the response; 2) a stage of resistance during which the defensive resources of the body are maintained at the level necessary for adaptive function-ing; and 3) a stage of exhaustion which occurs when the bodily resources are so depleted that further exposure to stress may lead to disintegration and death.

Selye emphasizes that the general adaptation syndrome is a non-specific bodily response which may be evoked by either physical or non-physical stressors. It is a phylogenetically old pattern of response preparing the organism for survival. However, under conditions of extreme or prolonged stress this initially adaptive neuro-endocrine response can produce in the individual symptoms of distress, physical malfunction or even structural damage.

Other physiologists have elaborated on Selye's concepts, and have included within their framework concepts evolving out of both psychological and social stress research. Levi (1974) has developed a conceptual model of psychosocial stress which includes: 1) the psychosocial stimuli; 2) the psycho-biological program of the individual which is a product of genetic factors and early environmental influence; 3) the

internal mechanism of the stress response; 4) precursors of disease which may include existing malfunctions in the individual's mental or physical systems which under certain conditions predisposes the individual to disease; and 5) interacting variables either extrinsic or intrinsic which might alter the course of disease.

Levi has stated that in his model, the sequence is not a one-way process, but part of a cybernetic system with continuous feedback. Thus Levi attempts to move from a linear model to view the individual and the process within the social context.

Physiological research on stress has provided tangible, biological evidence of the physiological changes that may attend stressful life events. In addition, it has provided measurable indices to assess those physiological changes. On the other hand, criticism has been levelled at physiological research which employs a rigid linear or medical model ignoring the mediating influence of psychological and social factors throughout the process.

A sociological concept of stress

From the sociological perspective, stress is viewed as an "adaptive challenge" that requires individual adjustment. (George 1980) "This process of adaptation depends on the degree of fit between the skills and capacities of individuals and their relevant supporting group structures on the one hand, and the types of challenges with which they are confronted on the other." (Mechanic, 1976, p.2) Research in

social stress has focused primarily on the "challenges" and "supporting group structures".

An extensive body of research (Rahe 1974) has examined the relationship between social stress and physical illness. Rahe and associates have gathered data on nearly 4000 subjects at the U.S. Navy Medical Neuropsychiatric Research Unit in San Diego. They have examined recent life events or changes experienced by these subjects at the personal, occupational or family level, and applied quantitative values to these life events according to a scale titled "The Schedule of Recent Experience Life Changes". This scale is presumably calibrated to reflect the degree of personal adjustment or adaptation required for each life event. Rahe has examined the relationship between illness and the number and intensity of these life changes. He hypothesizes that an accumulation of stressful life events, and the resulting adaptive responses required of the individual are associated with heightened emotional arousal and physiological changes which if prolonged result in illness.

Mechanic (1976) has argued that one achieves a more useful perspective on stress if it is viewed from both a societal and personal perspective at the same time. He has stated: "...psychological stress does not occur without the individual facing a threat of failure or loss; yet the meaning of failure or loss is dependent on social values and the acceptance of cultural definitions of what is valuable. It is the cultural meanings in any subgroup that determine what event will be

experienced as stressful." (p.5) Mechanic draws our attention to the societal institutions which prepare individuals to cope with challenge and adaptation; support them during their adaptive efforts; and reward successful adaptation. (Mechanic, 1970)

Sociological research on stress as it relates to illness has provided valuable insights into the significant role that social factors play both in initiating the adjustive demand, and in mediation throughout the process. Some social stress research has been criticized however for viewing the individual as playing a passive, reactive and undifferentiated role when faced with an adaptive challenge. Individuals are different- ially sensitive to life changes or stressful events. They bring to the event different perceptions or interpretations of the significance of those events. Adaptive responses are unique and individual, a product of both past experience, and a unique repertoire of coping skills. (McGrath 1970) Research directed towards the psychological implications of stress focuses our attention on the individual as the active, coping, adaptive centre of the process.

A psychological concept of stress

According to McGrath (1970): "...stress occurs when there is (perceived) substantial imbalance between environmental demand and the response capability of the focal organism under conditions where failure to meet demand has important (per- ceived) consequences." (p. 20) Research in psychological stress directs our attention to the importance of the

individual's perception of the stress situation; and its

potential significance to that individual.

> "If an environmental condition or event is
> appraised as benign (either realistically
> or defensively) no stress occurs at the
> psychological level, we should not antici-
> pate the physiological mobilization
> associated with stress emotions. More-
> over, even when harm is anticipated,
> effective preparatory coping activity or
> intrapsychic palliative modes of coping
> (e.g. defense mechanisms) may short
> circuit the threat, thus reducing or
> eliminating the anticipatory stress
> emotion at or before the point of confront-
> ation with harm." (Lazarus 1976, p. 11)

An environmental situation will produce psychological

stress when the central values or goals of an individual are

threatened. (Lazarus 1966) Although Marris (1975) speaks of

"change" rather than stress he also confirms this observation.

"The context of meaning and values from earliest childhood

becomes so structured and integrated that it cannot in time

be radically changed without fear of psychological disintegra-

tion. Our ability to handle the changing environment relies,

therefore, upon conserving the fundamental structure of mean-

ing each of us has grown up to." (p.19)

However, when this fundamental "structure of meaning" is

threatened, is the psychological stress that is engendered

an antecedent to the onset of disease? An extensive body

of research suggests that it is. (Engel 1968 & 1971);

(Schmale 1958); (Seligman 1975)

Engel (1968) over a period of five to six years collected

170 items from newspapers around the world that reported the

occurrence of sudden and unexplained death under unusual

circumstances. The circumstances under which the victims are reported to have died correspond with circumstances often observed to be associated with the onset of illness in general. All involved a sudden and unwelcome change in the victim's environment; and a corresponding sense of helplessness on the part of the victim to cope with this change. Engel observed that a psychological state of powerlessness or helplessness is commonly found to precede the onset of illness, and he has called this state "the giving up - given up complex". The five characteristics of the "giving up - given up complex" include: 1) affects of helplessness or hopelessness; 2) a depreciated image of oneself; 3) a loss of gratifications from relationships or roles in life; 4) a disruption of the sense of continuity between past, present and future; and 5) a reactivation of memories of earlier periods of giving up. (Engel 1968, p. 296) Engel hypothesizes that during this period of psychic disequilibrium the individual is biologic-ally susceptible to disease processes.

Schmale (1958) has documented a similar history of helplessness and hopelessness related to significant "object loss" just prior to the onset of illness. Seligman (1975) has argued that life changes that produce a psychological state of helplessness increase the risk of death. Each of these researchers believe that environmental events which produce a significant sense of loss and helplessness have some relation to the health and the subsequent chance of death in an individual.

A Model of Social Stress

One model which attempts to incorporate and integrate these three levels of analysis - physiological, sociological and psychological - has been developed by J.S. House (1974). It is difficult to conceptualize either the temporal dimensions or the complex interrelatedness of variables in a static model. However, this model of social stress by House includes five major classes of variables, and attempts to illustrate the relationship among the relevant concepts. It includes: " 1) objective social conditions conducive to stress; 2) individual perceptions of stress; 3) individual responses (physiological, affective and behavioral) to perceived stress; 4) more enduring outcomes of personal stress and responses thereto; and 5) individual and situational conditioning variables that specify the relationships among the first four set of factors." (House 1974, p. 13)

Figure 1 is an illustration of House's model. The solid lines indicate the direction of the stress sequence beginning with the objective social conditions. The broken lines indicate the influence of both social and individual conditioning variables which mediate during the sequence to moderate or exacerbate the original stress condition. The model might include a feedback loop from the final outcome which would indicate the reciprocal nature of the process as the final outcome measured in terms of the individual's physiological, behavioral and cognitive functioning may in turn influence the original stress condition, the conditioning variables
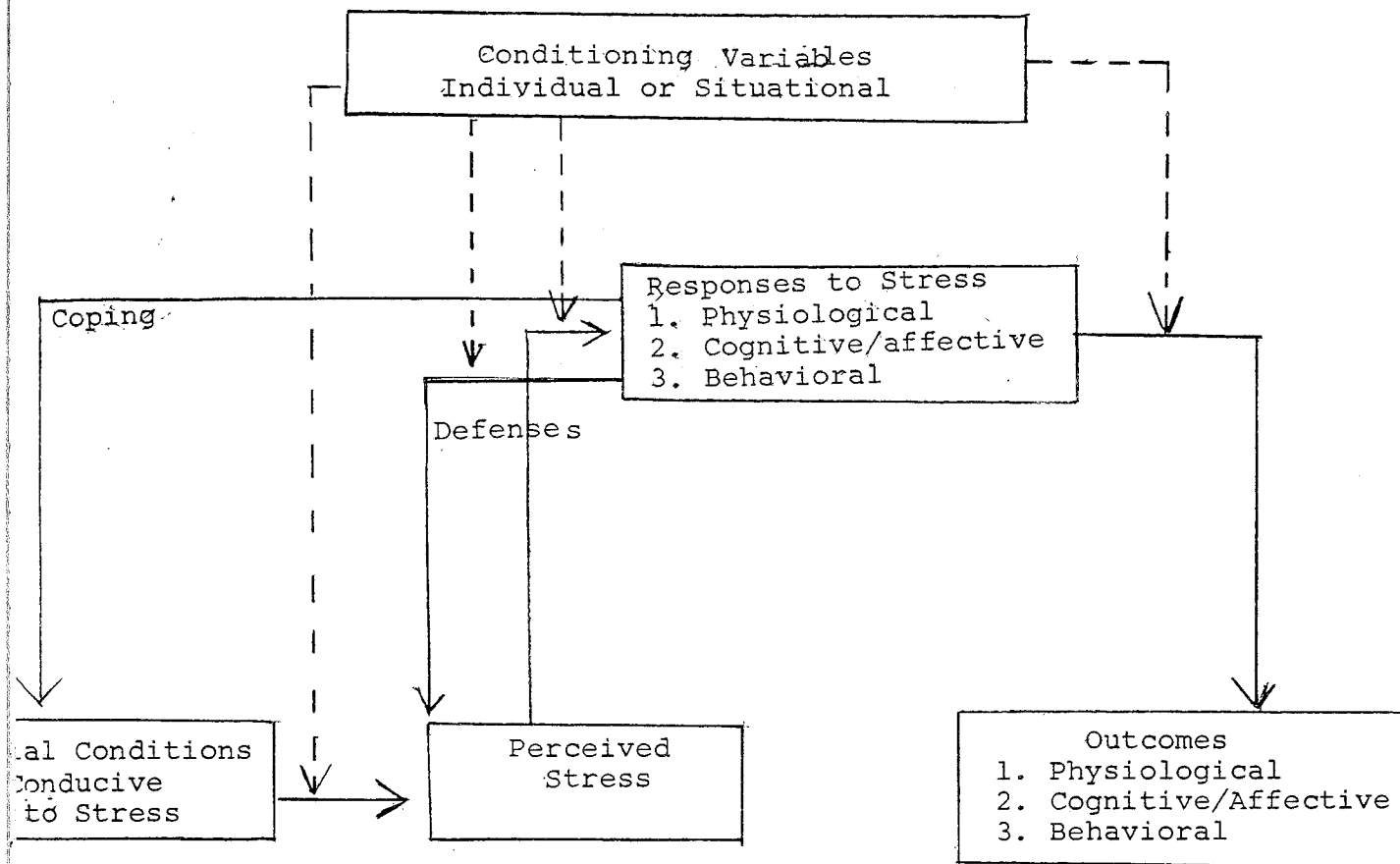
Figure 1: House's model of social stress. (From "Occupational Stress and Coronary Heart Disease: A Review and Theoretical Integration," by J.S. House, Journal of Health and Social Behavior, 1974, 15, 13.)

and the individual's future perceptions and responses when exposed to similar or new stress conditions.

Recognition of the complex interrelatedness among these variables, and of the processual nature of stress allows us to examine the research on relocation stress from a broader perspective. Research on relocation stress has seldom taken all of these variables into account in any single research design. However, through a composite review of the relevant literature, we can examine a number of these variables.

For the elderly, the degree of personal disruption experienced during relocation to a new environment appears to be a function of the following factors: "...the characteristics of the adjustive demand, the characteristics of the individual, and the external resources and supports available to him." (Coleman 1973, p. 170)

Relocation of and by itself is a significant adjustive demand, but for the elderly it is often only one of a pyramiding number of adjustive demands occassioned by declining health and functional ability, the loss through death of significant others, reduced social contacts and diminishing financial resources. As the work of Rahe and associates (1974) has shown the sheer number of demands may overload the adjustive capacity of the individual. Other characteristics of the adjustive demand which may increase the severity of the stress include the degree of change involved in the process of relocation, the perception of the move as voluntary or involuntary and the duration of the process.

The second factor, the constitutional and personality

characteristics of the individual is also of key importance. The capacity to withstand stressful change is in part a function of the immediate physical and emotional health of the individual; and with advancing age these physical resources may be already severely strained through chronic illness or disability. It is also related to the general stress tolerance of the individual and to their susceptibility to specific types of stress. A lower tolerance for specific stressors may be a consequence of past illness or traumatic experiences which may increase vulnerability at a later date. Closely related to such special vulnerabilities is the way the individual perceives or evaluates the situation. Lazarus (1966) views the individual's perception of the event rather than the objective situation itself as the key component, particularly so when the situation poses a threat to the individual's most central core of beliefs or values about self. The personality characteristics of the individual also play a part, including their strategies of defense, their coping mechanisms and their assumptions about reality and possibility.

The external resources and supports available to the individual is the third factor which will determine the degree of personal disruption experienced by an individual during stress. During relocation these supports may include the quality of the new environment in both physical and interpersonal terms; and the degree of preparation for the move. Adequate preparation must include both emotional support and physical assistance. And finally, the concern and support

of significant others including family and friends may be a crucial factor in alleviating stress and facilitating adjustment to the new environment.

MEASUREMENTS OF RELOCATION STRESS

Levels of stress have historically be measured in terms of physiological changes, alterations in behavioral responses, changes in the adequacy of cognitive functions and reports of disturbed affect. (Lazarus 1966) A number of these measures have been used as an index of relocation stress, the most common being mortality rates, changes in physiological status and measures of psychological well-being.

Physiological measures:

One of the most frequently used indices has measured relocation stress in terms of increased mortality rates. (Aldrich & Mendkoff 1963); (Killian 1970); (Markus et al 1971) More recently, researchers have examined changes in physical health using measures such as physician's ratings, self-perception of health, infirmary admissions and self reports on levels of daily functioning. (Bourestom & Tars 1974); (Borup et al 1980)

Two Canadian studies capitalizing on the extant research on physiological stress have examined increases in levels of plasma corticoids following relocation. (Farquhar & McCormick) (Kral & Berenson, 1968) Kral and Berenson(1968) found that levels of plasma corticoids increased among males and among psychotics of both sexes, but decreased slightly among

psychiatrically normal females. For males this rise in plasma corticoids was significantly associated with the development of physical complaints; although this increase was not necessarily accompanied by organic changes.

Psychosocial measures:

A frequently used indices in studies of intra-institutional relocation examines alterations in behavior including changes in levels of psychosocial activity and altered patterns of interaction. (Patnaik et al 1974); (Bourestom & Tars 1974)

Two longitudinal studies, have examined the effect of relocation on measures of cognitive functioning. Testing was conducted on subjects on a waiting list for placement, and again several months after entering the institution. (Weinstock & Bennet, 1971); (Tobin and Lieberman, 1976)

Measures have also been obtained on levels of life satisfaction and morale (Sherwood et al 1974), changes in self esteem and self-concept (Tobin & Lieberman 1976), and alterations in emotional state and levels of affect. (Brody et al 1974); (Miller & Lieberman 1965)

RESEARCH DESIGN AND RELOCATION STRESS

AN EXAMINATION OF MORTALITY RATES FOLLOWING RELOCATION

As mentioned earlier, a great number of studies have examined the relationship between institutional relocation and mortality rates. This research has focused on two types of relocation: 1) relocation from the community to an institution and 2) relocation from one institution to another. The

results of these studies have been somewhat ambiguous and contradictory. A number of reviewers (Blenkner 1967); (Kasl 1972); and (Rowland 1977) have noted these contradictions in the research findings and have attempted to explain these inconsistencies in terms of differences in research methodology. Since there may be a relationship between methodology and findings, an assessment of a number of these studies is necessary to achieve an understanding of the effects of relocation on mortality rates.

Three studies have examined mortality rates following relocation for the community to an institution.

Ferrari (1962) conducted a study on fifty-five females with an average age of 82 years who applied for admission to an old age home. Ferrari asked them upon admission how much freedom of choice they had felt in moving to the home, what other possibilities had been open to them and how much pressure their relatives had applied to them to enter the home. Of the 17 women who said they had no alternative but to move to the home, 8 died four weeks after admission, and 16 were dead in ten weeks. Apparently only one person of the 38 who saw an alternative died in the initial period.

Although these mortality rates seem excessive in comparison to mortality rates in the general population, the rates may in fact be a function of selection bias. It is not possible from Ferrari's study to determine to what extent this sample may have differed in health status from the beginning when compared with the elderly in general. Nor is it

possible to determine if the mortality rates were a function of relocation i.e. the environmental change; or a result of related changes perhaps associated with some aspect of the institutional environment such as poor diet, infection or poor medical care. (Kasl 1972, p. 378)

Other researchers have attempted to control for selection bias by using a waiting-list control group, assuming that the initial health status of a group waiting admission to a residential facility will be comparable to that of a group just admitted. This was the research design of Costello and Tanaka (1961) who reported a mortality rate of 38% in the first 6 months following admission, compared with an 11% death rate during a 1-month waiting-list period. As noted by Rowland (1977) when these rates are adjusted to compare equal intervals, the mortality rate for the waiting-list control group actually exceeds that of the admitted group.

It has been noted that the use of a waiting-list control group for comparison purposes controls to some extent selection bias between groups of movers and non-movers because health status between waiting-list and admitted groups is probably comparable. However, the similarities in health status between these two groups may be exaggerated. It is possible that the more severly impaired applicants are admitted preferentially, while the healthier applicants remain on the waiting list; thus confounding comparison of mortality rates between the two groups. From an ethical standpoint, controlling for this selection bias has not been possible since admission practices must reflect individual need.

Therefore, individuals cannot be randomly assigned to wait-ing-list or admission groups.

However, a study by Blenkner (1967) did employ an experimental design with random assignment of the community elderly to three service programs ranging from minimal intervention (providing information and direction to health and welfare services), to maximal intervention (an intensive program of direct service in which both social workers and public health nurses were active). At 6 month follow-up, the death rate on the maximal program (24%) was four times that of the minimal program (6%). In examining the nature of the service, researchers found that subjects on the maximal program were much more likely to have received a service directed at providing a more protected environment. That is, subjects on the maximal program were more frequently placed in institutional settings; and these placements were associated with higher mortality rates. Although the numbers in the program were too small to permit the results to attain statistical significance, later studies have produced similar results. The foregoing studies have led Blenkner to conclude: "There is a negative association between placement and survival among older persons which prevails even when their physical condition is held constant." (p. 101)

A much larger number of studies have examined relocation from one institution to another, or relocation to another ward or room within the same institution. These studies have utilized two research designs: 1) an experimental-control

design in which the death rates of movers are compared with the death rates of residents who are not moved; and 2) a base line design in which death rates after relocation are compared with death rates prior to relocation.

Studies employing the experimental-control design to examine mortality rates following relocation have produced inconsistent results.

In one study by Killian (1970) a mass transfer of hospitalized geriatric patients was arranged due to the closure of a satellite facility. The transferred patients were matched with a control group of non-movers on the basis of sex, race, organic or functional diagnosis, age, length of hospitalization and ambulatory or not at the time of transfer. Both groups were followed for a four month period. Killian found a significantly higher mortality rate for the relocated patients when compared to the matched control patients who were not transferred. An especially high death rated was observed for the older nonambulatory patients.

In a later study, Bourestom and Tars (1974) also matched the experimental and control groups on the basis of age, sex, length of hospitalization and diagnosis. These researchers studied two separate experimental groups: an experimental "radical environmental change" group and an experimental "moderate environmental change" group. These groups were transferred to two different facilities. The "radical change" group was transferred to a new facility containing a new staff and patient population. The "moderate change" group entered

a new facility, but staff and patient population remained
constant. Bourestom and Tars found a strikingly higher
mortality rate for the relocated groups; with the "radical
change" group experiencing the highest death rates.

In contrast, another group of researchers Borup et al
(1979) found no difference in mortality rates between groups
of transferred and non-transferred patients. However, these
researchers made no attempt to match the experimental and
control groups on relevant variables that might have contribut-
ed to the patients' chances of dying. Because the two groups
may not have been initially comparable, the results from this
study are open to question.

The second method for examining whether relocation is
predictive of death utilizes a baseline design which compares
mortality rates before and after the move. Several of these
studies have supported the notion that relocating an elderly
person results in an increased chance of death.

One such study by Aldrich and Mendkoff (1963) compared
the mortality rate for 180 relocated patients with a calcul-
ated anticipated death rate based on the death rates for 10
years prior to the relocation date. The mortality rate follow-
ing relocation was substantially and significantly higher than
the anticipated rate. In addition, these researchers found:
the death rate was concentrated in the first three months
following relocation; and the mortality rate also increased
during the period when patients were anticipating relocation
but had not yet been moved. However, this latter increase

was not statistically significant.

Jasnau (1967) measured the mortality rate following the mass transfer of a group of geriatric patients, and compared it with the mortality rate for the same period one year before relocation. The death rate for this group increased an astonishing 35 percent. This increase Jasnau attributed to a lack of adequate preparation for the move.

Two later studies have produced contradictory results. Zweig and Csank (1975) examined mortality rates when an entire patient population of disabled elderly veterans was moved into a new facility. These researchers compared post-relocation mortality rates for this population with the rates for each of the three years before the move, and found a significant decrease of 6.82 percent following relocation. Zweig and Csank credit an extensive preparatory program for these low mortality rates.

A second study by Gutman and Herbert (1976) also found a lower mortality rate post-transfer for a group of elderly chronic care patients. The mortality rate of the relocated patients for the year following relocation was lower than the mortality rate in 4 of the 5 years preceding the move. These researchers in a review of similar relocation studies noted that the data from these studies is often not truly comparable due to inconsistencies in sample size, sex and age mix, health status, degree of environmental change and the transfer procedures employed.

Borup et al (1979) have questioned the validity of the

baseline approach since it is contingent on the ability of researchers to establish a valid and comparable base from which to make a comparative analysis. Borup in examining the weakness of the design makes the following points: 1) mortality records which have been kept over a number of years may not necessarily be accurate or consistent due to vagaries of reporting and maintaining statistical records; 2) institut- ional policy in regards to maintaining patients who are approaching death may have changed over the years, and 3) the characteristics of the patients in the baseline group may not be similar to those possessed by the patients experiencing relocation due to differences over time in institutional admission policies, and the types of service offered. (p. 138)

From the foregoing review, it is apparent that the most convincing evidence of negative effects following relocation has come from studies in which institutionalized elderly were relocated from one institution to another. While evidence of a significant increase in mortality rates following relocation is not conclusive, nor always consistent, the findings are sufficiently alarming that Morton Lieberman, one of the pioneer researchers in this field has concluded that: "...no matter what the condition of the individual, the nature of the environment, or the degree of sophisticated preparation, relocation entails a higher than acceptable risk to the large majority of those being moved." (Lieberman 1974, p. 495)

Differential results in the foregoing studies cannot be attributed solely to methodological shortcomings in the studies themselves. Thus, the focus of relocation research has evolved

from simply measuring the impact of relocation in terms of
mortality or physiological and psychological changes, to
examining under what conditions, and with what kinds of
individuals are these negative effects most likely to occur.
(Bourestom & Pastalan, 1981)

What individual or situational characteristics may
moderate or aggravate the negative effects of the move?
Researchers have identified a number of these conditioning
variables that may help to explain variations in death rates
following institutional relocation. The conditioning variabl-
es which appear to influence the degree of personal distress
experienced during relocation were identified earlier in
this paper, and will be examined under the following head-
ings: 1) the characteristics of the adjustive demand: 2) the
characteristics of the individual; and 3) the external re-
sources and supports available to the individual.

CONDITIONING VARIABLES: INDIVIDUAL AND SITUATIONAL
VARIABLES THAT INFLUENCE OUTCOME FOLLOWING RELOCATION
Characteristics of the adjustive demand:

Available evidence indicates that relocation is a
significant and often traumatic adjustment for the older
person. As indicated earlier the results of a number of
studies have shown that elderly persons die at excessively
high rates during the first year and particularly during
the first three months following relocation; whether that
relocation consists of movement from the community to an

institution (Blenkner 1967), or movement from institution
to institution. (Aldrich & Mendkoff 1963), (Jasnau 1967)
Clinical observation of elderly persons during relocation
corroborates these research findings.

> "As the resident-to-be separates from independ-
> ent community living and intimate others, his
> attention begins to shift to the gains that can
> accrue from becoming institutionalized - principally
> care, people, and activities. The meaning of the
> losses connected with giving up independent living
> is separation; the experience is that of being
> abandoned, and reaction to it is extreme. Increas-
> ingly, the person becomes cognitively constricted,
> apathetic, unhappy, hopeless, depressed, anxious,
> and less dominant in relationships with others."
>   (Tobin & Lieberman 1976, p. 213)

As noted by the above authors, the adjustment process
is composed of two parts: the loss of familiar environmental
and social supports; and the necessary adjustment to a new
physical and psychosocial environment. This adjustment of
and by itself may tax the adaptive resources of the individual.
However, a number of characteristics of the adjustment
process have been identified which may place additional
strain on the individual amplifying their perception of
stress, and overloading their adaptive capacities.

These characteristics include: 1) the number of success-
ive adjustments the individual must make; 2) the degree of
change involved in the adjustment; 3) the individual's
perception of the adjustment as voluntary or involuntary;
and 4) the duration of the adjustive process. Each of these
will be examined in turn.

The decision to seek institutional care usually follows
a series of physical and social reversals. It is often the

culmination of a process that has already exacted a signifi-
cant toll. The following case example serves as an illustr-
ation.

> Mr. B. is 75 years of age. He has never
> married, and his only living relative is a
> very elderly and infirm aunt. For the past
> eleven years, since his retirement, Mr. B.
> has lived an independent existence in a small
> basement room in a private home. Most of his
> time was spent at a private gambling club where
> he regularly played cards with a group of other
> men. Although he suffered occassional financial
> losses, he also managed to win frequently enough
> to remain financially solvent. The pattern of
> his daily life, and his entire social contacts
> revolved about this club.

> However, during the past six months this
> pattern has been disrupted. A series of gambl-
> ing losses left him severely in debt, and he
> was no longer welcome at the club. All his for-
> mer social contacts were dissolved, and he enter-
> ed a period of social isolation and severe
> depression. A routine physical examination reveal-
> ed a malignancy in one lung, and following major
> surgery his general health deteriorated. The
> home in which he had lived was sold, and he
> received an eviction notice. He is now hospital-
> ized and awaiting placement in an institution.

This example illustrates one man's pathway to institut-
ionalization. Although it is unique, in some respects it is
not a typical. Institutionalization is often the climax of a
series of assaults that have undermined the individual's
personal resources and independence. Adaptation to an in-
stitution then requires a further expenditure of physical
and emotional energy from an already bankrupt supply.

A number of investigators have hypothesized that it
is the degree of change experienced during the relocation
process that is the crucial variable determining how
disruptive or destructive the move will be. As Lieberman (1969)

states: "The larger the difference between old and new situations, the greater the possibility that the aged individual will need to develop adaptive responses often beyond his capacity." (p. 334)

This hypothesis find support in the study by Bourestom and Tars (1974) cited earlier in which 98 residents were moved to two separate facilities. One group experienced a "radical environmental change" moving to a new facility with new staff and new programming. The second group experienced only a "moderate environmental change" moving to a new facility with staff and programming remaining constant. Mortality rates for the "radical change" group were significantly higher. In addition, following relocation, patients in this group "...grew increasingly pessimistic regarding the state of their health, withdrew from activities in which they had formerly engaged, exhibited lower levels of behavior, and were somewhat less inclined to perceive trust on the part of those with whom they came into contact." (p. 509)

Two additional researchers reinforce this view. (Watson & Buerkle 1976); (Gutman & Herbert 1976) In both these studies, mass involuntary transfers of geriatric patients were not followed by the expected increases in mortality rates. In these relocations, the degree of environmental change was moderate - staff, patient friendship patterns, daily routines and geographical location of facility remained the same. Watson and Buerkle (1976) note in discussion of their study: "...mortality/illness rates in involuntary transfer are

proportional to the amount of unfamiliarity associated with relocation, and when unfamiliarity is minimized, it may be possible to eliminate almost totally the special risk related to it." (p.282)

Markus et al (1972) conceptualize the relocation process as consisting of two separate stages: "...(a) deprivation of familiar cues and environmental supports and (b) coping with new sets of stimuli in an unfamiliar environment." (p. 376) During relocation the older person must become familiar with a new physical and psychosocial environment. Within this new environment customary behaviors and coping responses may no longer be functional. This is especially true when the degree of discontinuity between old and new environments is great. For example, while living independently within the community behavioral characteristics such as individuality, assertive-ness and independence may be necessary and effective coping mechanisms. These same characteristics may be discouraged within an institutional setting that fosters and rewards passivity, conformity and dependency.

There is evidence to suggest that involuntary relocation is particularly stressful for the elderly. This applies to community moves as well as to institutional relocation.

Two studies (Kasteler et al 1968), (Brand & Smith 1974) examined the personal and social adjustment of a sample of elderly persons following their enforced relocation due to urban renewal and highway construction. The relocated samples when compared with samples of non-movers within the community

showed greater life dissatisfaction, reduced activity and fewer social contacts. Relocation had apparently disrupted familiar social networks, causing a constriction in familiar activities with deleterious consequences for later life adjustment.

A study by Ferrari (1963) cited earlier, examined the lethal effect of involuntary relocation on a group of women entering institutions. Ferrari found a significant relation-ship between the lack of freedom of choice when entering an institution; and the subsequent death of the person. Of the 17 women who said they had no alternative but to move to the home, 8 died after four weeks in residence and 16 were dead in ten weeks.

The work of Seligman in the area of "learned helpless-ness" and Engel on the "giving up - given up complex" may help to explain these tragic consequences of involuntary relocation. Seligman (1975) has stated: "We should expect that when we remove the vestiges of control over the en-vironment of an already weakened human being, we may well kill him." (p. 186)

Clinical observation of the emotional responses of the elderly during an involuntary intra-institutional move are contained in a study by Locker and Rublin (1974). When 48 residents in an institution were forced to relocate due to legislative changes, an extensive program was launched to facilitate the move and if possible mitigate any negative effects. During a group meeting to announce the impending

move, the following reactions were noted:

> "When we first met with the groups of
> residents they were quiet at first and
> there was a general feeling of apprehen-
> sion. The group communication we had
> hoped for was minimal and predictable.
> Since they had no part in making the
> decisions, they felt powerless, in-
> significant and manipulated. Reactions
> expressed bore out feelings of impotence
> and anger. One hard-of-hearing man
> withdrew to the farthest end of the
> room." (p. 296)

One may question to what extent institutionalization
is ever truly voluntary. Declining health and social circum-
stances may necessitate the move. However, for the majority
of the elderly institutionalization is viewed as a surrender
of independence, and it is almost invariably approached with
fear and dread. Evidence of this reluctance is supplied
by Townsend (1962), who noted in his institutional survey
that "...rather fewer than a fifth (17 percent) took the
first step themselves..." (p. 230)

A final factor influencing the perceptions of stress
concerns the duration of the waiting period prior to institut-
ionalization. Recent studies have focused on the anxiety and
psychological changes associated with anticipating institut-
ionalization. (Tobin & Lieberman 1976); (Sherwood et al 1974);
(Zweig & Csank 1976). Lieberman (1969) notes: "...many of the
negative effects ascribed to living in an institution were
set in motion by the decision to enter an institution and
occurred with maximum intensity prior to actual entrance."

Longitudinal studies have examined changes in physical
health, psychological status and cognitive functioning

throughout the process of seeking, finding and anticipating
institutionalization. They have shown that the major
psychological impact associated with relocation occurs
during this waiting period. Given this information the
present situation of prolonged and uncertain waiting periods
prior to placement would appear to place an additional burden
on the elderly that can only create further distress.

Characteristics of the individual:

Researchers have begun to accumulate data on the character-
istics of those individuals who appear to be most vulnerable
to the environmental change associated with relocation. They
have examined elderly populations for significant variables-
demographic data; physical, mental and psychological status -
prior to a move; and then compared survivors and non-survivors
following relocation. For the most part, results from these
studies have been inconclusive.

Researchers have expressed hope that if such variables
could be successfully identified, differential programs might
be developed to ameliorate the risk for susceptible individuals
prior to relocation.

Examination of demographic factors has produced in-
consistent results. Killian (1970) reported no significant
differences between survivors and non-survivors associated
with sex; while the mean age of those dying was 8 to 10 years
higher than survivors. Kral and Berenson (1968) and Markus
et al (1972) found significant sex differences, but little
age difference.

In the area of physical health, Markus et al (1972) found a significant association between post-relocation mortality and impaired physical status and severe physical dependence prior to the move. These researchers note: "This finding likely indicates a general association between infirmity and death which might be expected among any aged population." (p.379)

Killian (1970) reported excess mortality rates among nonambulatory patients, a finding that contrasts with results obtained by Gutman and Herbert (1976), who found that the proportion of deaths was greater among ambulatory than among nonambulatory patients.

A variable that appears to more reliably discriminate between survivors and non-survivors is the degree of mental impairment prior to the move. Both the functionally disturbed and those with chronic brain disease appear to be vulnerable to relocation. Aldrich and Mendkoff (1963), found that "...among relocated residents, the psychotic or near-psychotic had the highest death rate." (p.192) Blenkner (1967) has noted: "One factor...emerges rather clearly and unequivocally as an indicator of "high risk". That factor is any evidence of severe brain dysfunction. When there is evidence that the older person's intellective capacity, his memory and his orientation to time, place and person are seriously impaired, his chances of survival following relocation are considerably lower than that of a person who shows no or only minimal signs of such impairment...". (p. 103)

Miller and Lieberman (1965) in a study of 45 relocated women found that "depressive affect" prior to relocation was significantly related to negative outcome following the move. This was supported in the study by Aldrich and Mendkoff (1963) which found that: "The death rate of neurotic, depressed and compulsive residents and of residents who denied their physical disabilities was three times as high as the death rate of residents with a satisfactory adjustment to the Home, and more than twice as high as that of residents whose adjustment was characterized by hostile and demanding behavior." (p. 92) In this same study, the authors found that a philosophical, angry or anxious response to stress was more adaptive than regression, depression or denial.

This was confirmed in a study by Tobin and Lieberman (1976) which noted that individuals who characteristically responded to stress with passivity were more vulnerable to negative effects following relocation.

In summary, the most effective predictors of a negative outcome following relocation appear to be severe physical or mental impairment, and a psychological pattern of adaptation characterized by passivity, depression, withdrawl, hopelessness and helplessness. On the other hand, relocatees displaying a vigorous, somewhat hostile-narcissistic coping style appear to adapt more easily to relocation. (Turner et al, 1972)

External resources and supports:

The external resources and supports available to the

individual is the third factor which will determine the

degree of personal disruption experienced during the stress

of relocation. These may include: the quality of the new

environment; the degree of preparation for the move; and the

quality of support from significant others.

A number of studies have examined the characteristics

of the elderly residing in homes for the aged. Lieberman

(1969) in a review of these studies suggests that institut-

ionalized elderly people share the following characteristics:

"...poor adjustment; depression and unhappiness; intellectual

ineffectiveness because of increased rigidity and low energy

(but not necessarily intellectual incompetence); negative

self-image; feelings of personal insignificance and impotence;

and a view of self as old. Residents tend to be docile and

submissive, to show a low range of interests and activities,

and to live in the past rather than the future. They are

withdrawn and unresponsive in relationships to others.

There is some suggestion that they have increased anxiety,

which at times has as a focus their own death."

The question remains, is this tragic portrait an effect

of the institutional milieu itself? Some studies suggest it

may be. When other institutionalized populations are examin-

ed the syndrome described above is replicated in these

populations. Bowlby (1952) has described the characteristics

of institutionalized children in the following way: "The

emotional tone is one of apprehension and sadness, there is

withdrawl from the environment amounting to rejection of

it, there is no attempt to contact a stranger and no
brightening if this stranger contacts him. Activities
are retarded and the child often sits or lies inert in a
dazed stupor. Insomnia is common and lack of appetite appears
to be universal. Weight is lost and the child becomes prone
to intercurrent infections. (p.22)

If this syndrome covers a wide spectrum of institution-
alized populations, what are the characteristics of institut-
ions which might ultimately be responsible for this effect?
The work of Goffman (1961) offers one explanation.

Goffman defines homes for the aged as one of grouping
of "total institutions". Total institutions share the
following features: all aspects of life are conducted in
the same place and under the same single authority; each
phase of the member's daily activity is carried on in the
immediate company of a large batch of others, all of whom
are treated alike and required to do the same thing to-
gether; all phases of the day's activities are tightly
scheduled, with one activity leading at a prearranged
time into the next, the whole sequence of activities being
imposed from above by a system of explicit formal rulings
and a body of officials; and the various enforced activities
are brought together into a single rational plan purported-
ly designed to fulfill the official aims of the institution.
(p.6)

According to Goffman, institutions which conform to
this bureaucratic model produce in the individual symptoms

of withdrawl and self-mortification. He notes: "...total institutions disrupt or defile precisely those actions that in civil society have the role of attesting to the actor and those in his presence that he has some command over his world, that he is a person with "adult" self-determination, autonomy and freedom of action." (p. 43)

Is this institutional syndrome an effect of the poorest of institutions; those homes in which the elderly are consistently subjected to "routinization, infantilization and desexualization"? (Brody 1977) One study of the social organization of care in a single nursing home by Gubrium (1975), poignantly describes this restriction of personal liberty and independence, and loss of privacy and autonomy. Tragically, the home which Gubrium describes would be considered by many to be a "good" home with a manifest belief in "total patient care" encompassing the physical, emotional social and spiritual needs of the residents.

A number of researchers have argued that it is an oversimplification to attribute all of the observed negative effects to the institutional regime itself. They believe these symptoms of institutionalization can be observed shortly after admission, and they are a product of the trauma of separation from the community.

Townsend (1962) suggests that the chief changes in an individual's psychology and behavior occur during the first days or weeks after admission to an institution. He notes: "The individual seems to receive an initial shock

which causes him to adjust quickly to a new level of behavior and to adopt certain new attitudes towards his environment and himself." (p. 367)

Tobin and Lieberman (1976) in a longitudinal study of community elderly entering care found that the most dramatic negative changes in psychological functioning occurred while the older person was awaiting admission. "The changes in psychological functioning from the "predecision" period to the period while awaiting admission were dramatically similar to those generally cited as induced by the harmful qualities of institutional life itself. This finding amply demonstrates how separation and anticipation of loss can affect psychological status, eventually painting a portrait no more desirable than that of institutionalized elder people." (p.214)

Some researchers, (Tobin and Lieberman 1976); (Weinstock and Bennet 1971) have noted stability or improvement in psychological functioning after entering the institution. These results are significant if we accept that institutionalization for some elderly is necessary and unavoidable given their degree of physical infirmity and lack of social supports. It is imperative therefore, to examine institutional environments that do not appear to produce these negative effects. From a review of the literature, Liebowitz (1974) concludes that a "good" institutional setting would include these characteristics: it would encourage independent behavior; offer respectful attitudes, concern and affection; provide opportunities for constructive activities and social

interaction; and provide access to the outside community.
(p. 293)

The degree of preparation for the move appears to be
another factor affecting the individual's perception of
stress during relocation. Evidence suggests that one of
the most effective means of ameliorating the impact of
institutionalization, or intra-institutional moves resides
in sensitive preparation for the move through careful
casework service and psychological support. A number of
researchers have credited improved survival rates following
relocation to extensive preparatory programs. (Jasnau 1967)
(Wittels & Botwinick 1974); (Gutman & Herbert 1976)

Jasnau (1967) found significantly lower death rates
for patients transferred individually to nursing homes
following an extensive program of preparation than for
patients mass-moved within the hospital with little or no
preparation. Preparation included: "...educational programs
at all levels of hospital and nursing-home staffs and per-
sonnel, and included the psychologic and emotional prepar-
ation of the patient for the transfer through social case-
work services." (p. 284) Although Jasnau did not control
for other differences which may have existed between the
two groups, he concluded that adequate preparation "...can
reduce the trauma associated with change for the older
patient."

An extensive preparatory program reported by Novick
(1967) was initiated when the entire population of the

Maimonides Hospital in Montreal was moved to a new facility. Preparations included: involving the residents through their Patients' Club in the process of decision making on important problems of design for the new facility; scheduling frequent bus trips to the new site so residents could observe the progress during construction of the new facility; and construction at the old hospital of a life-size model of one of the new rooms so that residents could become accustomed to them. In addition, residents concerns and wishes regarding roommates in the new facility, and the transfer of personal belongings was given special attention. Every effort was made to ensure continuity of staff, and to involve family, friends and volunteers in the process. In this study, not only did the mortality rate not increase following relocation, but it was 9.8 percent below the normal annual mortality rate. Novick noting this unusual decrease in mortality rates credits not only the preparatory program, but also the environment of the new building which was designed to allow individual privacy, while at the same time providing areas that encouraged maximum interaction on an intimate basis.

Although a somewhat less extensive preparatory program was employed, Zweig and Csank (1976) observed a similar decrease in mortality rates following the mass transfer of geriatric patients to a new facility. These authors note that: "...a good stress-prevention program is the essential requirement for reducing mortality and averting catastrophe."

(p. 276)   They have outlined some of the features which pre-
paratory programs should include: the feelings of the patients
are the primary consideration and perhaps procedures for
familiarization with the environment are secondary; the
beginning of a stress-prevention program must be unobtrusive
and keyed to the level of the most sensitive patient; the
program must be introduced in a gradual and orderly manner,
and special steps should be taken to prevent disruption of
routines; staff orientation with regard to the needs of
vulnerable subgroups should be the first and most important
part of the program; and a successful stress-prevention
program should not be halted until the danger of after-
effects of relocation have disappeared. (p. 276)

The final factor of importance in alleviating stress
during relocation is the involvement of significant family
members and friends. In the vast majority of the fore-
going studies, the crucial role of family members in the
relocation process has not been considered.

This deficiency may be partially explained by statistical
data that indicates that in general those in institutions
are more likely to lack or to have lost close supportive
relatives. Townsend (1962) in his United Kingdom survey
of institutional facilities for the aged found that more
widowed older people, more unmarrieds, more childless people,
and more with only one adult child lived in institutions.
In fact, "...those with no surviving children formed 51
percent of the sample." (p. 290)   Studies from the United

States corroborate these figures. Brody (1977) reports
that only about 10 percent of the institutionalized elderly
are married, while 63 percent are widowed, 22 percent have
never married, and 5 percent are divorced. While statistical
data on residential populations in Canada is not available,
surveys of the community elderly as reported by Statistics
Canada (1976) have noted a similar trend. Among the age
group most susceptible to institutionalization, the pro-
portion widowed increases sharply. During 1976, 56 percent of
women aged 65-69 were married, however by age 80 and over,
less than 15 percent were married.

A common misperception which is not confirmed by
available evidence concerns the belief that the institution-
alized elderly have been abandoned by uncaring relatives.
In truth, in most instances the decision to place an
elderly family member in care is made with great reluctance
and only after other avenues of care have been exhausted.
In many cases, institutionalization follows long periods
during which relatives have expended physical and emotional
energy and financial resources in an attempt to maintain
the older person in the community. When institutionalization
becomes an inevitable and necessary reality, family members
must often cope not only with their own feelings of guilt, but
with the elderly person's feeling of anger, rejection and
abandonment.

Following institutionalization, available relatives
continue to play an important and vital - albeit somewhat

different role. (Gubruim 1975); (Miller & Beer 1977);
(Tobin & Lieberman 1976). Gubruim reports that involved
and concerned children are the "currency" of the institut-
ionalized elderly that purchases status amongst their peers.
Tobin and Lieberman note the important role of children:
"...in carry(ing) on traditions and values (that) help the
elderly achieve a personal resolution with death, a feeling
that one's life has been a meaningful one." (p. 231) Relatives
provide a sense of continuity amidst the discontinuity of
environmental change; and also maintain necessary linkages
with the community that has been left behind.

The significant role of family members in sustain-
ing and supporting the older person throughout the process
of institutionalization has been examined by Brody and
Spark (1966). They have stated: "The importance of "family"
to the child has been universally accepted. The need of
the aged person for "family" is no less vital. Whether the
aged person lives under a separate roof or in a distant city,
he continues as a member of an organic family group. His
situation inevitably affects and is affected by each
individual member of that family." (p. 78)

PART II: STUDIES OF THE INSTITUTIONALIZED ELDERLY

INTRODUCTION

As noted in the foregoing literature review, relocation can under certain conditions, and with certain kinds of individuals pose serious risks to the physical and psychological well-being of elderly persons. In view of the possible negative consequences of relocation, under what circumstances does institutionalization appear to be indicated? In seeking an answer to this question, some literature on elderly institutionalized populations will be examined. Researchers have studied institutionalization rates, the characteristics of institutional populations, and the precipitating factors that lead elderly persons to seek institutional care. In Part II of this paper, a number of these studies will be reviewed.

It should be noted however, that the majority of these studies have been garnered from British and American publications. When they were available, Canadian studies have been utilized. Elderly institutionalized populations in different countries may not be strictly comparable. Institutional care is a particular social response to the problems that may be associated with aging. While institutionalization may be sought as a response to the real health and social needs of individuals, the type of care provided, and the circumstances under which it is utilized also reflect the prevailing cultural norms and values of a society in relation to their beliefs about aging, and the needs of aging people; and the role that the state and the family should each play in meeting those needs.

STATISTICAL DATA ON INSTITUTIONALIZATION OF THE ELDERLY
IN CANADA AND BRITISH COLUMBIA

It is difficult to obtain accurate statistics on the
number of institutionalized Canadians 65 years and over.
Firstly, the data available from Statistics Canada does not
separate short-stay from long-term cases. Statistics are
available on institutional rates for the elderly, but statistics
relating exclusively to the "institutionalized" elderly,
(which may be defined as those committed to institutional care
for a period exceeding two months), are not available. The
second difficulty arises over the definition of institutions.
The definition may encompass a wide variety of settings,
including congregate residential facilities exclusively
housing the elderly, quasi-institutional settings providing
some centralized health and/or social services, and full
institutional care provided within a hospital setting. Many
statistics do not define the level of care provided.

With these limitations in mind, the latest statistics
available from Statistics Canada (1976) estimate that in that
year, 8.4 percent of the population 65 years and over were
receiving some form of institutional care. In the same year in
British Columbia, 16,807 persons, or approximately 6.9 percent
of the elderly population were receiving institutional care in
General and Allied Special Hospitals, Special Care Facilities
and Mental Health Facilities. (Schwenger & Gross, 1980)
Within the province of British Columbia at the present time,
(April, 1981), 15,965 persons are receiving institutional

care under the Long-Term Care Residential Program. An

additional 6,489 persons are residing in extended care

facilites which are administered under the Division of

Institutional Services, Ministry of Health. Extended care

facilities provide skilled twenty-four-hour a day nursing

services and continuing medical supervision. (Bayley, 1981)

In addition, a further 2,811 long-term care beds have been

approved for construction, or are under construction and will

be completed before 1982. (Ministry of Health Annual Report,

1979) Even so, the present construction rate cannot keep

pace with the demand for institutional services. As a result,

in 1980, one in six acute care beds in British Columbia was

occupied by a long term patient awaiting institutionalization.

(Padmore, 1981)

The above figures bear witness to the high level of

institutionalization among Canada's older population. Schwenger

and Gross (1980) have estimated that in the province of Ontario

in 1976, out of the total population 65 years and older re-

ceiving institutional care, about one-percent were in short-

stay care. If that statistic is applied throughout Canada,

our rate of institutionalization for aged Canadians is almost

7.5 percent. Although comparisons of institutionalization

rates among countries must be approached with caution because

of the aforementioned inconsistencies in the definition of

"institution", this Canadian statistic (7.5 percent) is consider-

ed excessive when compared to rates of institutionalization in

Great Britain (5.1 percent), and the United States (6.3 percent).

(Schwenger & Gross, 1980, p. 251)

As a number of researchers have noted, statistics on institutionalization rates are misleading in that they are based on cross-sectional rather than longitudinal data. The percentage of the population 65 years and over in institutions at any one time is not the same as the percentage of the over-65 population which will become institutionalized before they die. In an American study, an examination of death certificates filed for individuals over 65 revealed that as many as 20 percent occurred in nursing home facilities. (Ingram & Barry, 1977) Palmore (1976), has estimated that the chances of becoming an institutional resident among normal aged persons living in the community is about one in four. The total chance of institutionalization increases progressively with advancing age. For those over age 75 in Canada, 15 percent are estimated to be in institutions at any one time, (The Special Committee of the Senate on Aging, 1966, p. 107): and for the over 85 age group, the number institutionalized increases further to a staggering 39 percent. (Marshall, 1981)

CHARACTERISTICS OF ELDERLY RESIDENTIAL POPULATIONS

Any examination of the characteristics of the institutionalized elderly must take into account both the variation among individual residents, and the variation among facilities which may provide significantly different levels of care. With this reservation, the available literature has provided a fairly comprehensive picture of institutional residents.

Who among the elderly are most likely to seek institutional care? First, as noted above, it is the oldest of the old. The average age of institutional residents is 82 years; and 70 percent of residents are over 70 years of age. (Gelfand & Olsen, 1980) Women outnumber men in institutional populations by 3 to 1. (Gelfand & Olsen, 1980) However, women outnumber men among the aged in general, (about 5 to 4 in the total 65 and over population in British Columbia). The longer life expectancy of women makes them more vulnerable to widowhood and the illnesses associated with aging; and both these conditions are correlated with an increased likelihood of institutionalization.

When compared to community populations of elderly people, institutional residents have significantly less economic resources. A Canadian study credited this difference in part to the fact that the community elderly are most likely to have a living spouse, and so report a combined retirement income. In addition, this study reported that 14 percent of their community sample in spite of their advanced age, were still employed. (Kraus et al, 1976a)

Elderly institutionalized residents suffer from multiple chronic physical disabilities. (Brody, 1977) Many of these ailments result in functional incapacity which impairs ambulation, and other activities of daily living. Surveys of institutional residents have found that less than 50 percent of residents are fully ambulatory; 55 percent are impaired in self-care activities, and 25-33 percent are incontinent. (Butler, 1977); (Gelfand & Olsen, 1980)

Mental disorders are extremely prevalent amongst institutionalized residents. As researchers have noted, mental impairment parallels physical functional decline. Impaired mental and impaired physical function in a large portion of aged persons are simply two aspects of the same disorder. (Goldfarb, 1961) Statistics from the United States indicate that the number of mentally impaired aged living in institutions in that country is high. A national survey of nursing homes found that 34 percent of the population had "advanced senility", and 27 percent "less serious senility"; Another 17 percent had other mental disorders such as mental illness or retardation. (Brody, 1977)

In Canada, the number of mentally impaired elderly residing in long-term care institutions is difficult to estimate. Part of the difficulty lies in accurately defining the term "mentally impaired". It is estimated that approximately 7 to 8 percent of those over 65 years of age exhibit some "confusion". (Black, 1978) This is however a global term encompassing both functional and organic mental disturbance. In one Canadian study of a residential population, only 33 percent of the sample were scored as normal on a Dementia Scale developed by the researchers. (Kraus et al, 1976a)

In British Columbia, the psychogeriatric resident is defined as: "...an individual who in addition to confusion and impaired comprehension exhibit(s) anti-social habits,...destructive, aggressive or violent behavior,...continually wander(s) away; or may endanger his or her own life." (Hanbury, 1981)

Depending on the degree of mental disturbance, psychogeriatric residents may be receiving care either in Valleyview Hospital established as a treatment facility for the psychogeriatric patient, or in one of the facilities administered under the Long-Term Care Residential Program. The number of psycho-geriatric residents in any one Long-Term Care facility is dependent on the capacity of the facility to provide the physical setting, staffing and programming to meet the special needs of these elderly residents.

As noted, residential populations are overwhelmingly composed of the very old, with multiple physical and/or mental impairments. However, the majority of the very sick and frail elderly are not in institutions; they are living in their own homes, or in the homes of family members. (Shanas, 1979) A Canadian health survey has reported that the number of community elderly with a significant health problem, and/or functional disability rises from 5.5 percent of the population between the ages of 60 to 64; to 35.5 percent of the population in the 85 plus age group. (Marshall, 1981) It is apparent that the elderly who resort to institutional care must differ in some other way from their non-institutionalized peers.

Researchers have noted one significant difference in residential populations is their lack of family resources. Townsend (1965), has written: "...the likelihood of admission to an institution in old age...is partly contingent on family composition, structure and organization and not only on incapacity, homelessness and lack of socio-economic resources."

Family structure, (marital status and living arrangements), provides one indication of the potential availability of kin to provide support should the need arise. Surveys of residential populations have consistently found that widowed and unmarried people make up the majority of institutionalized residents. (Brody, 1977) In the general population of elderly in Canada, 80.4 percent of males 65-69 years of age are married; for women the number is 66.6 percent. However, for the 70 plus age group, less than a third of the women are married, and by age 80 and over, more than 85 percent of women have been widowed. (Abu-Laban, 1980) This latter group of aged widows are potentially a vulnerable category within the aging population.

In examing living arrangements, researchers have found that the elderly most commonly live with family, - either with a spouse or children. In Canada, 74.1 percent of males over 65 live with family; for women the figure is 53.5 percent. Only 11.1 percent of males 65 and over live alone, while 24.6 percent of women live on their own. (Abu-Laban, 1980.) Palmore (1976), found that the elderly living alone had a significantly higher rate of institutionalization since they were less likely to have someone to care for them if they became physically or mentally incapacitated.

The institutionalized elderly may also lack the support of adult children. The elderly with no children, and those with only one or two have a higher rate of institutionalization than do those with several. Childless, or low fertility

women have a 15 percent higher chance of institutionalization before the age of 75 than do women who have 3 or more children. (Treas, 1977) Apparently, the elderly fare better when several children are available to share caregiving functions when such help becomes necessary. Family support can delay or prevent institutionalization, even for those elderly with significant infirmities. Researchers consistently note that persons living alone prior to admission are significantly less infirm upon admission than persons living with their children or others. (Townsend, 1965); (Barney, 1977)

Of significance are the number of residents with no living close relatives. An American study reports that more than 50 percent of residents have no family close by. (Gelfand & Olsen, 1980) This was confirmed in a survey of a sample of institutionalized residents in Vancouver in which 45 percent of the sample reported no close relatives living in the Vancouver area. (Hanvey & McLachlan, 1981) These figures indicate that one of the contributing factors to institutional admissions may be the lack of family support that might enable the older person to continue living in his or her own home.

PRECIPITATING FACTORS CONTRIBUTING TO INSTITUTIONALIZATION

As noted above, long-term care institutions are occupied by very old residents, most of whom have multiple chronic physical and mental impairments, and many of whom have no close family on whom to rely. Each of these factors, (advanced age, declining health, lack of family resources), or more reliably a combination of these factors, may

precipitate the decision to seek institutional care.

However, practitioners working in the community with the elderly are aware that institutional placement is almost invariably sought only as a "last resort"; and numbers of older persons with similar incapacities and lack of support resist institutional placement to the end. Do the elderly who seek placement differ from their community cohorts? Or are their circumstances sufficiently different that institutional care is a necessary and appropriate solution to their immediate needs?

In an attempt to answer these questions, a number of surveys of residential populations have been conducted in order to gain an understanding of the residents' self-perceptions of the precipitating factors that led them to seek institutional care.

While some studies have identified a single major life disruption that precipitated the decision to move, (Beaver, 1979); other studies have emphasized multiple causation for application for admission to an institution. (Brody, 1969); (Tobin & Lieberman, 1976) These multiple precipitating factors have been identified as: 1) social isolation engendered by a lack of close relatives or friends; the loss of supporting relatives; or adverse changes in relationships with significant others. (Townsend, 1965); (Barney, 1977); 2) lack of adequate housing brought about through loss of the former home; or house and/or neighbourhood deterioration (Beaver, 1979); 3) economic insecurity (Townsend, 1962); 4) a new

specific health problem, or a worsening of a chronic health problem resulting in the inability or anticipated inability for self-care. (Kraus et al, 1976b); 5) the unavailability of community resources or services that might maintain the older person in the community. (Brody, 1977); and 6) the unwillingness or inability of family members to carry the burden of care necessary to maintain the elderly person in the community. (Brody, 1966)

In addition, Brody and Gummer (1967) and Brody (1969) have noted that although applicants and non-applicants for residential care shared certain similarities in demographic characteristics, those actually making application differed in the following ways. Those making application offered more reasons for their need for institutional care than did non-applicants; they had attitudes which appeared more positive to institutionalization; and also had relatives more favorably disposed toward admission than those of non-applicants.

A similar survey was recently conducted in Vancouver with a sample of institutional residents. The residents were asked to state their reasons for moving; and asked to specify the most important reason(s). Out of this sample, 65 percent of the subjects reported health problems as the primary or single factor for moving to a care facility. Fifteen percent moved because of a lack of social support; and 15 percent moved primarily because of dissatisfaction with their neighbors or location. Falling or accidents was given as a major

consideration by one subject. In the sample, half also provided additional or secondary reasons for moving. Thirty percent reported that they also moved for emotional health reasons, 30 percent for lack of social supports, 20 percent because of dissatisfaction with the neighbourhood, 5 percent because of falls, and 5 percent because of difficulties with home maintenance. (Hanvey, & McLachlan, 1981)

How accurately do these surveys "tap" the decision-making process? The "reasons for admission" as stated by half the residents in the above sample was limited to one response; however, the case histories which the survey uncovered were invariably convoluted and complex reflecting multiple stressors and changes prior to the move. In the following case history, this resident gave as the reason for moving an inability to live on her own "for health reasons".

> Mrs. D. is 76 years of age. She has had Parkinsons Disease since 1935, and her condition has steadily worsened. She now walks with a cane, and her speech is badly impaired. Although she manages her own self-care, her ability to care for a household or shop independently is severely limited.
>
> She was widowed in 1934, and raised her two children alone by working as a school teacher in spite of her progressively debilitating illness. Following retirement, she moved into an apartment and managed on her own for 10 years. A little over a year ago, she fell in her apartment, and her doctor suggested that she no longer live alone.
>
> She moved to Vancouver and lived with her daughter, son-in-law and grandchildren. During that year, her daughter and son-in-law separated, and her daughter was forced to sell the home and return to work. At that point, Mrs. D. decided to enter care

Mrs. D. is a remarkably cheerful lady in spite
of her obvious disabilities. She states she is happy
with the decision she made and commented: "It was
easier to make the decision now - its easier to
adapt when you're younger - and besides, I've had
lots of changes in my life, so I'm well adapted to
things".

As this case history reveals, the reasons for seeking

placement are almost invariably complex and manifold.

Institutional residents do not differ markedly from their

community peers. They have invariably suffered a series of

severe assaults, - physical, social, economic and environmental.

Given their physical, emotional and social needs, their avail-

able supports, and their coping abilities, institutionalization

appears at the time to be the only available option. The

question of course remains, in Mrs. D.'s case, could addition-

al family resources, or supplementary community resources have

been mobilized to postpone or prevent institutional placement?

Or was institutionalization perhaps the most appropriate

response for this woman, at this time in her life?

WHEN IS INSTITUTIONALIZATION INDICATED?

Practitioners working in the field of institutional assess-

ment and placement constantly confront the question. Barney

(1977), has suggested that assessment of need for placement

should examine four areas: 1) the need for assistance; 2) the

availability of financial resources; 3) the presence of social

supports; and 4) the expression of personal preference. Social

supports are here defined as both family and community re-

sources.

The majority of practitioners working in the community

with the frail elderly would agree that family and community
supports can in many instances be utilized as an alternative
to institutional placement. However, practitioners also
recognize that under certain circumstances these necessary
social supports are either unavailable, inadequate or even
inappropriate.

Both research and clinical evidence indicates that
families do help, particularly in time of illness: exchange
of services and regular visits are common among old people and
their children and relatives, whether or not they live under a
single roof. (Shanas, 1979) The extent of family help has
been demonstrated in a number of studies. A Canadian survey
of newly admitted elderly residents, found that 64 percent of
the sample who were receiving help from the family just prior
to admission, had either been taken into the family home, or
were receiving total or extensive help. (Kraus et al, 1976a)
A Vancouver study confirms this finding. In the Vancouver
sample, 55 percent of the residents had close relatives nearby.
Prior to admission, all those residents with close relatives
nearby had received extensive help from them; 80 percent of this
group had received this assistance on a daily basis. (Hanvey
& McLachlan, 1981)

The burden this care imposes on family members is
considerable. One researcher in a review of studies, found
that two-fifths of offspring caring for elderly parents in
their homes devoted the equivalent of a full time job, (with
overtime), to custodial tasks. (Bengston & Treas, 1980)

Breakdown occurs when the person involved in providing home support can no longer cope. Sanford (1975), in England, found that the least tolerable problem for the supporting person was disturbed sleep, - sleep interruption brought about by night wandering, incontinence and shouting.

Over a period of time, this constant and wearing level of responsibility may no longer be tolerable. One survey of residents' family members found that when these family members were asked to state the most important reason why they had made application for the admission of the parent to an institutional facility, 51 percent of interviewed family members mentioned that caring for the elderly parent was imposing an excessive burden on the family. (Kraus et al, 1976b) This burden is especially onerous when the caregiver is also aging.

Increasingly, institutionalized residents have adult children who are themselves aging. When a survey of applicants to a facility was conducted over a 6 month period, almost 40 percent of the applicants had at least one adult child over 60 years of age. (Brody, 1966) Due to improvements in mortality, there are increasing numbers of four-generation families. (Streib, 1972) As a result, the "children" of institutionalized parents may themselves be experiencing the physical, social and economic stresses of aging. Brody (1966) has noted: "...the adult children's own problems of aging have become more apparent and more frequent as precipitants or as major contributing factors in the family disturbance leading to the need for placement of the parent." (p. 202)

One survey found that 36 percent of newly admitted
residents had been living with relatives who were themselves ill,
infirm or of advanced age. (Townsend, 1965) Other studies have
noted that an increasing number of applications for institution-
al care come about as a result of the death or severe illness
of an adult child, or an adult child's spouse. (Brody, 1966)

Could a range of community services supply sufficient
relief for these overburdened relatives that aging parents
could still be maintained either in their own home, or in
the relatives' home? Some studies indicate they cannot.
When the families of newly admitted residents were interview-
ed in one facility, and asked if they would have liked, or
needed more information on community alternatives to placement,
only 33 percent felt this would have been helpful. Thirty
percent of this sample had taken the aging parent into their
home; a large proportion of the remaining families had
supplied extensive, and regular help. At the time of place-
ment, relatives were exhausted and defeated, and for a
large majority of these families, no alternatives would have
been acceptable at that time. (York & Caslyn, 1977)

In many cases, community services in sufficient quantities
can supplement the care of concerned relatives, and in the
absence of family can provide substitute care. However, in
other instances this is not possible. Even with access to
day care services, transportation and homemaker services, an
aging person with severe functional incapacities, combined
with emotional or mental disturbance may seriously jeaprodize

his own safety, or the safety of others. Tragically, this same combination of disabilities, (advanced age, and physical and mental impairment), is most commonly associated with lethal consequences following relocation.

Certainly, maintenance in the community is not possible without a whole range of medical, social and homemaker services. Even then, economic or environmental hazards may limit the effectiveness of these services. An experienced administrator in this field has stated: "It is not possible to build constructive in-home services around an impossible home situation; I mean impossible because of poverty with its associated bad housing, inadequate nutrition and general deprivation." (Trager, 1969) When an aging person requires twenty-four hour a day care, home support care may not be the most suitable, or fiscally responsible alternative. This does not imply however that institutional care is the only other option. Instead, health care planners could develop sheltered and special housing alternatives, such as foster home care and other congregate non-institutional housing that would provide the necessary supportive services, and some measure of protection and supervision, while still preserving for the elderly person the greatest possible degree of independence and self-determination.

An additional consideration in the decision-making process is of course the personal preference of the elderly person. Milloy (1964), has stated: "...plans for living arrangements should be based on the principle that as long

as a person gains more gratification than pain from living
in the community, it is better to help him remain there."
(p. 454) Research evidence indicates that non-voluntary
placement of the aged can have lethal effects. Practitioners
in the field have all had experience with the elderly person
who in spite of serious physical limitations, inadequate
housing and support services, is so adamant about remaining
in his familiar setting that placement appears to be contra-
indicated in spite of concerns for his safety.

Can the worker balance the wishes of this aging person
against the needs of an anxious and overburdened family and
help them all arrive at an adequate and equitable solution?
The official policy of the Long-Term Care Program in
British Columbia as stated in the philosophy of the program
is: "...the program must...respect the right of the family
to request the transfer of individuals from the family's
home to approved facilities in the community, when that
individual's continued presence in their home is detrimental
to the health of their family." (Introduction to the Program
for Long-Term Care, 1978)

The role of the community social worker in these instances
is particularly difficult and stressful as she attempts to
stabilize the system by generating further community services
while providing emotional support for all concerned through
her continued presence and empathic understanding.

The final decision on who "should" be institutionalized,
and at what time, cannot be established by official policy, nor

decided on philosophical grounds. It is a highly individualized decision. As Brody (1977), has stated: "The ultimate decision is based on evaluation of the total situation: the older person's resources (physical, mental, functional, social), the family's resources and the available community resources." (p. 120) Once the decision has been made however, it is imperative that services exist so that the process of institutionalization itself can be handled with skill and sensitivity.

PART III: THE RELOCATION PROCESS: SOCIAL WORK PRACTICE
IMPLICATIONS

INTRODUCTION

The first two sections of this paper have been primarily
research-oriented, concerned with examining a number of re-
search studies on relocation stress, and also surveys of the
institutionalized elderly. This final section will focus
specifically on clinical practice, and one particular type of
relocation - the transition from the community to an institution.

There is general agreement amongst researchers that
community to institution relocation is potentially more stress-
ful than either relocation from one community setting to
another, or relocation within or between institutions. The
elderly person encounters profound environmental discontinuity
following this transition from home to institution. He
probably experiences a reduction in familiar roles and contacts
with significant others. He also experiences the loss of
intimate environmental supports following the disposition of
home and belongings. Following transfer to the institution,
he must become familiar with a new physical and psychosocial
environment. This requires adaptation to an institutional
milieu with unfamiliar residents and staff, and an institut-
ional routine that constrains and directs his activities. In
addition, he may have to deal with the emotional pain that
accompanies the sense of having been rejected or abandoned by
family members; and the cultural stigma that is associated
with institutional living - a stigma that connotates defeat

in the struggle to maintain an independent life. (Aulinger, 1979)

Research evidence indicates that this struggle to adapt to perceived losses and separation from the familiar occurs with maximum intensity during the waiting period preceding admission to institutional care. Therefore, a number of researchers have described the relocation process in terms of a sequence of stages or phases, beginning with the situational changes which precipitate the decision to move; and ending several months after relocation following a period of adjustment. Tobin and Lieberman (1976) have broken this sequence into four stages: 1) the phase of predecision; 2) the phase of anticipating relocation; 3) the phase of initial adjustment; and 4) the phase of adaptation which encompasses the first several months after the initial adjustment. Utilizing the phases or stages developed by these authors, this section of the paper will examine particular intervention strategies that might be applied throughout the process of relocation to facilitate the transition from community to institution.

As noted earlier in this paper, the focus of relocation research has evolved from simply measuring the impact of relocation in terms of mortality or physiological and psychological changes, to examining under what conditions, and with what kinds of individuals are these negative effects most likely to occur. Researchers have identified a number of factors, or conditioning variables which appear to most significantly affect the outcome of relocation, and these

have been discussed.

The utility of this research lies in its ability to inform and direct social workers who are actively assisting in the relocation process. The identification of significant variables affecting the outcome of relocation provides the framework for the evolution of strategies that will hopefully mitigate the negative consequences of relocation. The worker can then give that framework substance through the development of specific policies and programs that will facilitate the process of relocation. In addition to this research-generated knowledge, the social worker brings to the process, knowledge of the resources and services that are presently available in the community; the particular values and skills that are a part of his or her profession; and the use of self within the helping relationship.

However, workers are also often constrained by inadequate or non-existent policies, programs and resources; and a lack of sufficient staff, time or agency support. While the particular intervention strategies that will be discussed have not explicitly recognized these constraints, the writer is aware they do exist, and is also aware of the frustration these constraints produce for workers in the field.

The evolution of the intervention strategies that follow developed out of both practice experience and numerous discussions with workers involved in community services with the elderly, assesors working out of Public Health Units in the province, and administrators, nurses and social work staff in

a number of facilities. While some of the recommendations may appear impossibly removed from the realities of the present situation, they also express the real hopes and concerns of these workers who are actively involved in the assessment and placement process, and who also wish to see changes in the present system. Their contribution to this paper is gratefully acknowledged.

In addition, I would like to acknowledge a debt to the clients who allowed me to share their experiences throughout the process of relocation. They gave the research on relocation both substance and new meaning.

THE RELOCATION PROCESS: SOCIAL WORK PRACTICE IMPLICATIONS

The Phase of Predecision

For a minority of the community elderly, there is a stage in the process of aging when the cumulative stresses and losses associated with this period of life are too heavy a burden to be carried independently. The process has usually been gradual. The elderly person has been able to make the necessary adaptations to role losses, to physical decrements, and to the loss of friends and family members. The most recent crisis, - perhaps the loss of a significant source of support, a recurring illness, eviction from a home-, while only one in a series of crisis, is sufficiently devastating that help is sought from outside sources; and an application is made for institutional care.

Although significant differences exist among applicants,

the characteristics of the institutional residents as noted
earlier are also fairly typical at the point of application.
The applicant is probably very old, has several chronic
physical conditions, with a considerable degree of functional
disability, and may suffer some mental impairment, notably
memory loss and confusion. Only a minority of applicants
have a living spouse; and approximately half of the applicants
will have adult children nearby. (Brody, 1977)

For those with adult children, there is reliable evidence
that in the vast majority of cases, the adult child has been
actively involved in efforts to maintain the elderly parent
in the community. As the parent's capacity for self-care
deteriorated, the child has provided extensive instrumental
and affective support, often on a daily basis. This has
included in about half the cases moving the elderly parent
into the child's home. (Shanas, 1960) By the time applica-
tion for care is made, the adult child has often exhausted
their own physical and emotional resources, and this final
decision to seek institutional care is made with great
reluctance, and only as a last resort.

In other instances, the assessment and placement procedure
takes place within an acute care hospital setting. A large
number of applications are made through acute care hospitals
following a fall, or a sudden and debilitating illness. The
number of patient transfers directly from hospitals to
institutional facilities is probably extensive, statistics
vary from 25 percent to 59 percent. (McPhee,1977), (York &

Caslyn, 1977), (Cape, 1977), (Hanvey & McLachlan, 1981) In
these instances, the physician and hospital social worker in
collaboration with family members are instrumental in making
the decision that institutional care is necessary at this time.

Sudden and severe illness can produce in the elderly
person temporary disorientation and confusion. This mental
state, in combination with the presenting illness can present
an alarming picture to family members concerned about the
elderly person's capacity for self-care upon discharge. During
this crisis period, precipitate and unilateral decisions may
be made with tragic consequences. At the present time, rehab-
ilitation facilities for the elderly are inadequate or non-
existent. These facilities would provide an interim period
for restoration and re-evaluation, following which the assess-
ment of need either for institutional or community care could
be carried out under less stressful circumstances.

Whether it takes place in the community, or in a hospital
setting, the application for admission to care is often init-
iated under conditions of severe stress. It is seldom the
elderly person himself who suggests placement, or instigates
the application process. Studies have shown that only 17 to
19 percent of applications are initiated by the elderly person
himself. (Townsend, 1962), (Kraus et al, 1976b), (York &
Caslyn, 1977) One study noted that 46 percent of the elderly
persons who were entering care were involved in the decision-
making process "very little or not at all". (Kraus et al,
1976b) Considering the information that is now available on

the negative consequences of involuntary admission, the implications of these statistics are alarming.

From the moment of application, the primary focus of the assessment worker should be to obtain the participation and involvement of all concerned participants, - both the older person, and all family members. Participation must be more than mere acquiescence to the wishes or decision of others. While the older person's participation may be limited by his physical and mental condition; and his options may be circumscribed by present circumstances, to whatever extent possible the worker must encourage his active involvement. The same holds true for family members. Whatever decision is reached, it will ultimately affect all family members; and their needs and concerns must also be respected, and taken into account. Whether the participants decide on institutional placement, or a community alternative, the families continued cooperation and participation will be essential to the future well-being of the older person. The seeds of this cooperation should be sown during the assessment process.

During this predecision phase of the relocation process, the worker's tasks are to counsel, assess, and screen. (Brody, 1977) In reality, these tasks cannot be separated, but are carried out concurrently. Assessment should include an evaluation of three areas: the client's present physical, mental, functional and social status; the family's current functioning and capacity for support; and the availability of both community and institutional services. Counselling services

should assist both the elderly person, and the family to appraise the various alternatives, and reach decisions on the services that are most appropriate to their needs. Case - work services for both client and family should be an integral part of this process. If institutional care is the service chosen, screening coordinates the client's functional status and needs with the eligibility criteria and services of a particular facility.

The skills of the worker during this period will be critical in preventing unnecessary or premature admission to a facility. A statement by Barney (1977), is basic to all long-term care planning: "...no degree of need for long term health care and other supportive services automatically indicates the setting in which that care should be provided. All levels of care can be given, (and frequently are given) at home" (p. 309). The number of elderly persons who are inappropriately placed in facilities has been well documented. American studies estimate figures of from 15 to 47 percent. (Holmes & Holmes, 1979). Recent Canadian studies confirm these figures. In London, Ontario, a recent study examined facilities providing three levels of care. Considering each level separately, researchers found that 25 to 54 percent of the residents had been inappropriately placed. (Cape, 1977) A study of 193 applicants for institutional care noted that non-institutional placement would have been more suitable for almost a third of the applicants. (Kraus et al, 1976b) Every worker involved in the application phase of the relocation process should constantly keep these statistics in mind.

The first request for application to a facility will probably be initiated by a family member, or a physician. It should be viewed initially without prejudice simply as a request for assistance. The first focus of the worker should be to explore whether this is indeed the choice of the elderly person. Are the participants knowledgable about community alternatives? Have these alternatives already been suggested and rejected out of hand; or have they been attempted previously without success?

If the choice of the elderly person, (and/or family), is to first explore the possibility of "independent" community living, the primary goal of the worker is to structure a community support system. When the client is elderly and frail the difficulty of developing, and maintaining a supportive community environment should not be underestimated, as the following case example will illustrate.

> Mr. B. is 78 years of age. He is single, and the only family support consists of a young niece who is both responsible and concerned, but is not available on any consistent basis. Mr. B. has a serious heart condition, and is almost totally blind. He has recently been hospitalized following a stroke which has left him disabled to the extent that he now walks with two canes.

> His income is barely adequate to cover food and the cost of a walk-up, one room apartment. Access to this apartment is via a steep staircase, without handrails. His only cooking facilities consist of a two-burner hot plate.

> Over the past few years, his heart condition and failing vision have limited his social participation, and he is now socially isolated. He is however, fiercely independent, and insists that his only choice would be to return home.

Developing a community support plan for this man required the cooperation of a geriatric rehabilitation team consisting of the physician, nursing supervisor, social worker, occupational therapist and physiotherapist. It also required collaboration with community workers including, a community social worker, home care nurse, homemaker supervisor, meal service supervisor and a day-care supervisor. The assistance of his niece was also elicited both for occassional supervision, and for socialization. The landlord in the building was contacted to obtain his agreement to provide handrails for stairs and bathroom.

Few hospital settings provide the services of a geriatric assessment team in spite of clinical evidence that it is not possible to structure adequate community supports without information on the client's medical, social, functional and environmental needs. Moreover, once a supportive environment has been developed, it must be maintained, (and when necessary modified), within the community through regular supervision and collaboration with all those concerned. At the present time, community workers are simply not available to provide this consistent case-management and follow-up service. Recently a survey was conducted in Vancouver of a sample of elderly people receiving homemaker service. The sample was asked how often they had follow-up contact with the community worker or assessor who had conducted their initial assessment. Seventy-nine percent of the sample reported no follow-up contact; seventy-four percent were unable to provide the name of their

assessor; and sixty-nine percent did not know how to make
contact with the assessor. (Haramia & Hanvey, 1981)

At the present time, many elderly persons in British
Columbia have access to both professional consultation, and
to a wide range of health and social services through their
local community Public Health offices, Human Resources
offices and volunteer organizations. However, the full
range of services that are required in order to develop a
comprehensive community support system for the elderly may
not be available in every community. These services for
convenience can be arbitrarily divided into five categories.
(Barney, 1977) It includes:
1) a "facilitating" category comprised of counseling, advocacy
and transportation services; 2) a "living at home" category
including homemaker and handyman services and meals-on-wheels;
3) a health concerns category providing a range of home
health care services, i.e. nursing, speech therapy, physio-
therapy; 4) an economic concerns category which provides
information and referral with respect to government income
supplements, rental supplements, and subsidized housing; and
5) a social integration category comprised of services such
as friendly visitors, telephone reassurance and day care
centres.

Some of these services, (i.e. meal service and health
care), can be delivered either on an individualized home-
delivered basis, or on a semi-institutional or congregate
basis. They can be designed to cover a wide range of health

care needs, from preventive care to maintenance or rehab-
ilitation care.

The above services can supplement the care provided
by family members; or provide substitute care when family
are not available. As noted earlier however, they may not
provide the caregiver with sufficient support, particularly
when a single family member has assumed the responsibility
of looking after a very frail incapacitated parent; and this
responsibility has been carried over a long period of time
with no provision for relief.

At the present time, there is an inadequate supply of
the more intensive backstopping services for families that
would buttress the home care families presently provide.
Sussman (1976), has called these the "halfway to institution-
alization" services that utilize an institutional setting to
provide either temporary, intermittent or occassional
institutional care as required. These services might include:
short-term crisis care during an illness, or intensive
convalescent or rehabilitation care to restore former function-
ing; the provision of day and/or night institutional beds to
provide half-time relief; and the provision of respite beds
during short vacation periods.

These services would operationalize the "theory of
shared functions", which states that formal organizations
and families must coordinate their efforts in order to
provide optimum care for the aging. (Streib, 1972) The filial
responsibility of adult children toward their aging parents

has been well documented. (Sussman, 1977) Surveys have con-
sistently noted the considerable number of frail elderly
who manage to remain in the community, cared for by their
families with varying degrees of supplementary support
supplied by public and voluntary agencies. These supplementary
services can be defined as: "...those that primarily substitute
for the family and those that attempt to support the family".
(Moroney, 1976, p. 118) At the present time, we lack adequate
data on the type of support which families would find most
helpful in order to obtain some relief from the pressure of
providing full-time care. We need information on which social
services and programs, (i.e. financial assistance, practical
help), would most effectively support and reinforce the
services which families now provide, thereby freeing adult
children to provide the affective and social supports which
bureaucracies cannot provide. (Treas, 1977)

When efforts to maintain the elderly person in the
community have failed to provide the necessary support, or
when institutional care is the preferred choice of the
applicant, the worker's task is to provide assessment,
counseling and screening services to facilitate placement
in an institution.

Lawton (1970), has defined the major task of assessment
as: "...one of optimizing the congruence of personal character-
istics and environmental resources. The patient's physical
and mental well-being depend on his not being challenged
beyond his resources. This is the whole rational basis for

the search for assessment instruments that will screen
applicants or provide favorable placement decisions." (p.39)
In effect, formal assessment measures the individual's status
and abilities in order to determine the level or type of
institutional care that will best meet his needs. The
assessment procedure is simplified and attains greater
objectivity if standardized instruments are used; and if they
are applied by trained professionals.

There is considerable controversy over the utility
and validity of various assessment instruments. However,
there is general agreement that assessment of need for long-
term care facilities should include functional capacities in
addition to a medical evaluation. Functional assessment is
"...any systematic attempt to measure objectively the level
at which a person is functioning in any of a variety of areas
such as physical health, quality of self-maintenance, quality
of role activity, intellectual status, social activity,
attitude toward the world and towards self, and emotional
status". (Lawton, 1971)

The assessment instrument provides an objective method
of evaluating the status of the individual and their capacity
to perform a range of tasks, -i.e. self-care-, that are
relevant to functioning in a particular institutional
environment. However, individuals are more than the sum of
their functional capacities, and workers must be constantly
aware that instrumentation only supplements, and does not
replace the worker's skill and sensitivity in individualizing
the assessment and placement decision.

As noted earlier when discussing assessment for community placement, the value of team assessment has been well documented. The problems of the elderly seeking placement are "multi-symptomatic", and the solutions to these problems are best found by a team of assessors, each with their own area of professional expertise. (Brearley, 1977)

When the Long-Term Care Program in British Columbia was first established, the program was designed to conform to this principle of team assessment. Assessment teams making recommendations on institutional placement were to be composed of the local long-term care administrator, a nurse, a social worker, the family physician, a mental health worker (when required), and a representative of the Facility where the applicant was to be placed. Theoretically, this composite team would provide detailed information on the individual needs of the applicant seeking placement, and whether those needs were congruent with the services and programs of the facility the individual had chosen. This is still the design of choice. Both community and hospital settings should provide this assessment service.

Until such time as this service is established, workers must take responsibility for individualizing the placement process through their recognition that long-term care applicants are not an homogenous population. Assessment and screening for placement should not be limited to establishing care level requirements and then simply giving the applicant a list of facilities that meet those requirements. Individuals

have unique histories, personalities, interest and needs.
These must be considered when recommending specific facilities.

Recent research has explored the possibility of reducing
morbidity and mortality following relocation by selecting an
institutional environment that is congruent with the personal
characteristics of the individual. (Tobin & Lieberman, 1976)
In theory, personality/environmental congruence should reduce
the environmental discontinuity that has been implicated as
a factor in relocation stress. One researcher, Kahana (1973),
has attempted to identify the most salient dimensions of
congruence. She reports: "When there is a lack of congruence
between the individuals' needs for privacy and for immediate
need gratification these incongruences (are) especially likely
to lead to unhappiness". (p. 288)

Environmental differences between institutions are not
simply a qualitative issue. Institutions of similar quality
may differ significantly due to the characteristics of the
residential population, and to administrative philosophy in
relation to issues such as programming and institutional
control. (Tobin & Lieberman, 1976)

In reality, screening for individual/institutional "fit"
involves some very practical problems including the availabil-
ity, geographic accessibility and acceptability of the
institution. Studies have shown that applicants and/or
families are most likely to choose an institution on the
basis of the availability of a bed, on the location of the
facility, or on the recommendation of their physician or

friends. (York & Caslyn, 1977), (Kraus et al, 1976b)

While taking these applicant/family considerations into account, the worker should also base her recommendations on the idiosyncratic life style and needs of individual applicants. If an applicant has a well-established pattern of watching television all night, and then dozing intermittently through-out the day, he will require either a private room, or a very tolerant night staff. The applicant who has never adhered to regular meal hours will probably be happier in an institution that provides kitchen facilities for the use of residents, rather than in one that insists on rigid conformity to meal time.

In order to make these recommendations, workers must have comprehensive and current information on each long-term care facility. This should include information on: the physical facilities and layout; staff/resident ratios and the number and type of professional staff on site; the programming and services available; the accessibility of the institution to community facilities and activities; whether the physical layout permits both socialization and privacy; the extent of resident freedom and influence; and the degree of flexibility or rigidity in the institutional routine.

Instrumentation exists to make this type of institutional assessment, (Moos et al, 1979); but it would require both funding and direction from Long-Term Care administration to permit the collection and publication of this data. In addition to having access to this printed material, workers should also be encouraged to make on-site visits to facilities

in their geographic area.

This information on facilities should also be made available to applicants and families seeking placement. Researchers have found that families require guidance in assessing the quality of institutions. In one study, when families were asked the reasons for selecting a particular facility, only 10 percent mentioned the quality of physical care; 12 percent the quality of the activity program; and 35 percent the quality of the staff. (York & Caslyn, 1977) This is consistent with another study that found that the quality of meals was a highly significant factor in family judgements of the quality of a facility. (Linn & Gurel, 1969)

The Committee on Aging of the Social Planning and Review Council of B.C. produced a booklet in 1976 entitled, "Citizen's Guide to Adult Care Residences in B.C.". It was produced as a selection guide for applicants and for families to use when choosing a facility. The Guide drew attention to areas such as: the care provided; the location; the admission policies and regulations; the living space; the communal areas; and the services within the facility. It offered check-lists for facility comparison, and generally assisted individuals and families in making more knowledgable decisions on placement. Although it is an excellent booklet, it has become outdated following implementation of the Long-Term Care Program. A similar booklet should be produced to aid applicant's in the selection process.

A significant number of applicants, (from 40 to 50 percent), have never visited the facility prior to their admission. (Pope, 1979), (York & Caslyn, 1977), (Kraus et al, 1976b) This is probably not uncommon for those individuals who are assessed in a hospital who do not have relatives available to arrange transportation for the visit. With the exception of seriously ill or incapacitated individuals, hospital policy should encourage workers to arrange for facility visits. Possibly hospital volunteer organizations could provide this service. A similar policy should apply in the community. Applicants are entering a permanent living arrangement. The facility will be their future home, and they must have every opportunity to familiarize themselves with the setting and personnel in order to ease the shock of transition.

When applicants are ambulatory and moving from their home to an institution, facility visits should include more than a cursory tour of the institution. Applicants could join other residents for activities, or for a meal. A room should be available in the facility to allow for over-night visits if applicants so choose. These services would allow elderly persons to realistically appraise and anticipate institutional life.

All of the foregoing services: comprehensive information on available facilities; a guide to the selection process; and the opportunity to visit facilities prior to the move should be an integral part of the pre-decision process. Any measure which increases the applicant's ability to make a

meaningful choice, or prepares him for the move, allows the elderly person to gain some sense of control in a situation that is generally marked by feelings of extreme helplessness and powerlessness.

Throughout this pre-decision phase, casework assistance should be available to both the elderly person and to family members to permit expression of the feelings, problems and reactions that inevitably accompany the decision-making process.

Although the potential for both personal and family disruption exists during this period, the worker must be aware that the feelings of loss, helplessness and grief that are so often present are not necessarily pathological, but are a natural component of this major life change. The majority of families manage to negotiate this transition as they have others, not without pain, but with love and respect intact.

The decision to seek placement is almost never initiated by the elderly person, and seldom have physical or emotional preparations been made for this eventuality. While the older person may recognize at one level the necessity for placement, feelings of rejection, loss, and anger predominate. Fearing that expression of these feelings will only alienate the family support so essential to his well-being, he may instead respond with self-blame, depression and withdrawl.

During this period, the worker can be instrumental in helping the elderly person recognize and accept their anger;

and can provide a safe focus for the ventilation of these feelings. Evidence has shown that expression of these feelings is not only necessary, but indeed may be life-saving. (Aldrich & Mendkoff, 1963)

Family members may also be torn by feelings of guilt and self-blame. These are poignantly expressed in the words of a 64 year old woman following the institutionalization of her 92-year-old mother.

> "The guilt feelings suffered by some children have different sources: that the individual isn't living up to his or her ego-ideal, some ethical concept of filial behavior that directs one to be loving, attentive, patient and dedicated to the parent's care. In conflict with this is the natural need for one's own growth and survival which when frustrated results in resentment, anger even hatred which is turned inward. The resulting depression hampers further the healthy handling of the situation."
> (Bengston & Treas, 1980, p. 419)

Family members can be helped to accept the reality of both their own, and their parent's needs. Accepting this reality may help to alleviate any pervasive sense of guilt, inadequacy and betrayal. Adult children are often labouring under a deeply internalized cultural belief that responsible children do not abandon their parents to institutional care.

It is the role of the worker to help the family recognize that filial responsibility can take many forms. By relinquishing the wearing physical care of an aging parent, children can be free to give the invaluable emotional support which only they can provide, and which is so central to the parent's well-being. While institutionalization may modify existing roles and responsibilities, the relationship

between parent and child can continue to be meaningful within the institutional setting.

THE PHASE OF ANTICIPATING RELOCATION

Longitudinal research data on the process of institution-alization indicates that this anticipatory phase is a crisis period for the elderly person. Tobin and Lieberman (1976), have written: "The changes in psychological functioning from the "predecision" period to the period while awaiting admission were dramatically similar to those generally cited as induced by the harmful qualities of institutional life itself. This finding amply demonstrates how separation and anticipation of loss can affect psychological status, eventually painting a portrait no more desirable than that of institutionalized elder people". (p. 214)

Considering the stress and changes associated with this period these findings are not surprising. Generally, the wait-ing period for institutionalization is not only prolonged, but also uncertain. The stressors which precipitated the decision to move, - illness, inadequate housing, family conflict -, have not been resolved. Preparations for the disposal of treasured belongings must begin and arrangements are made to leave the family home. Assistance and physical energy are required for these tasks, both of which may be in short supply.

While Canadian studies are not available, American studies have indicated that this period is marked by frequent moves, probably precipitated both by the uncertainty of the waiting

period, and by increasing physical deterioration. One study found that during the first year after application, while on the waiting list, 73 percent moved at least once, and many moved several times. These applicants moved at least five times as often as older people in the general community. (Brody, 1977)

Generally, these moves are into the home of a family member. Another study which observed this shift in living arrangements found that fully 68 percent of the applicants awaiting institutionalization were living with family just prior to placement. (Miller & Harris, 1965) These temporary living arrangements require further personal adjustment, and may also be the source of family strain or conflict.

Programs and services can ease the stress of this waiting period, and in some measure prepare the elderly person for the impending move. A worker should be available to every applicant to ensure continuity of service throughout this period. As noted, the waiting period is almost inevitably prolonged due to chronic bed shortages, and the condition and needs of the client and family should be regularly monitored to keep abreast of changes or sudden emergencies. Both concrete services and casework support should be provided.

During this period arrangements should be made for home support services as needed, (i.e. meals-on-wheels, homemaker assistance), especially if the client is living on their own. Day care services can either supply interim relief for families or provide needed socialization for the isolated older person.

The client who is alone will also require assistance with the packing and disposal of household belongings. It is most important that if possible the client feel in control of this process; that sufficient time is allowed, and that it is handled with care and sensitivity. Community resources to assist with this task are almost non-existent, and it often requires considerable resourcefulness on the part of the worker to find volunteer assistance.

The worker can provide consultation on the belongings that can be moved to the institution. These familiar possessions invariably provide a valuable link with the community, and with the past, and are particularly significant in the face of so many losses.

In addition to these concrete services, exposure to the institutional setting prior to the move may help to reduce the anxiety and fear that are associated with the unfamiliar. When possible, linkages with the facility should be encouraged by occassional visits, and participation in institutional activities. The applicant can become familiar with the institutional setting, the staff, the available resources and services, and also with the residents. During these visits, specific concerns and problems and concerns can be discussed with the facility worker. The applicant gains a more realistic picture of institutional living, and may possibly perceive the move as promising gains to off-set the many losses.

Formal preparatory programs have been developed for

intra-institutional moves on the occassion of forced relocation of large numbers of residents. The value of these programs in terms of reduced mortality has been documented. (Gutman & Herbert, 1976), (Zweig & Csank, 1976) More recently, researchers have begun to develop formal intervention programs for the pre-admission period utilizing similar techniques. These programs are based on the theoretical perspective that increasing control and predictability, will in turn reduce the stress of relocation. (Schulz & Brenner, 1977) Two such programs have been suggested by researchers in British Columbia.

The first of these programs, entitled Preparation for Relocation of the Elderly, (PREP), was developed for the non-ambulatory, housebound client who is relocating to an extended care facility. These elderly persons due to physical incapacity are most often unable to visit the facility prior to their move. To take the place of these on-site visits, a slide-tape presentation is delivered to the elderly person's home by a trained therapist, who is also available to answer questions and provide further information.

The PREP program has three main components: 1) the applicant's sense of predictability is increased through films that provide familiarization with the physical layout, the staff and resources of the institution; during these films, some typical problems that are often associated with entering care are also discussed; 2) the applicant is taught specific stress management techniques, including problem-solving, positive thinking and relaxation to increase their sense of

personal control; and 3) a group meeting is held for the sponsors or families of applicants to provide them with relevant information on relocation, to teach them the stress-management techniques, and to elicit their cooperation and involvement throughout the process.

PREP was developed as part of a research study to examine the effect of preparatory programs on the elderly person's subsequent adjustment within the institution. Final outcome data on the study is not presently available.

The second program suggested by Grant and Gutman (1980), is initiated prior to admission, but is specifically designed to help applicant's cope with the institutional environment once they have entered care. This program is also directed to increasing the applicant's sense of personal control by identifying coping skills that will facilitate adaptation to a new environment. While the PREP program attempts to teach new coping skills through their stress-management techniques, this program utilizes coping skills which are already part of the elderly person's repertoire. The worker elicits from the applicant specific recollections about how the elderly person coped in the past. By re-living such events, both good strategies (to use), and bad strategies (to avoid), are evoked. These familiar strategies can then be employed by the elderly person during relocation, and after entering care.

Components of these programs could be adapted by workers and selectively used with individual clients. The most

significant elements of these programs appear to be: access
to adequate information about the mechanics of the move, and
about the new setting; the opportunity for ventilation of
concerns and anxiety in relation to the move; and an individ-
ualized program of problem-solving strategies.

While family members can be an invaluable resource to
the elderly person during this waiting period, their own needs
and concerns must also be considered. In one facility, a
family group program was established for family members during
the pre-admission period to meet both these objectives.
(Manaster, 1967) The first goal of the program was to increase
the adult child's awareness of what it means to enter an
institution in order to increase their understanding of the
aging parent's behavior and feelings. The second goal was
to help the adult child become aware of their own feelings
and reactions, and the manner in which those feelings were
affecting the relationship between themselves and their
parents.

Group members found they were able to attain a greater
sense of objectivity by sharing experiences and reactions
that were common to all. Within the group they could
acknowledge feelings of anger and frustration at the end-
less responsibility, and also feelings of relief at the
prospect of the parent's impending move, without feeling
these reactions were either unique or aberrant. They could
also recognize the universality of the parent's feelings and
behaviors as the time for admission drew near.

These group sessions within the institution also provided an opportunity for family members to meet with facility staff and perceive the facility as a resource, not only for the elderly person, but for the family as well. At the same time, facility staff were able to gain a more complete picture of the aging parent, not simply as a future resident, but as a member of a functioning family unit.

THE PHASE OF INITIAL ADJUSTMENT

It is doubtful whether even the most conscientious preparation and support prior to admission can adequately prepare the elderly person for the initial shock of institutionalization. Moreover, it is the fortunate older person who has had access to this pre-admission preparation. There are still instances where elderly persons are transferred alone from hospital, and deposited on an unfamiliar institutional doorstep with no more than a paper bag containing their few personal possessions.

What does the elderly person experience during this stage of initial impact? What adjustments must he make?

First, the new resident's familiar environment is replaced by an institutional room that may be clean and functional, but bears no similarity to the treasured familiar clutter of home. In most instances, that room must be shared, with all the problems of accommodation and tolerance entailed in adapting to the preferences and life style of another older person.

The institutional environment itself is a constant re-

minder that the residence has been designed to accommodate the sick and elderly; and it usually resembles a hospital setting more than a home. The variety and hierarchy of the institutional staff is confusing, and these people must be sorted out in order to obtain the necessary services. One of the most difficult adjustments for the new residents involves adapting the familiar rythmn of his days to the inflexible institutional routine of established hours for sleeping, eating, bathing and socializing. He must not only become familiar with the formal rules and regulations of the institution, but also with the informal order and conventions of the residential population.

Informal and regular contact with neighbours, friends and family is reduced to the ritual of scheduled visits. The residential population is composed of other infirm and possibly confused elderly residents, and association with this population in itself may promote a self-perception of ill health and inadequacy. In the midst of this residential life, privacy becomes a precious commodity, which often must be actively sought.

Admission to an institution has been likened to profound culture shock. (Yawney & Slover, 1973) Adaptation to this unfamiliar culture requires an expenditure of physical and emotional energy that has already been depleted by ill health and the stress of relocating. This is the stage in the re-location process that is often marked not only by increased morbidity and mortality, but also be increased anxiety, dis-

orientation and depression.

Preparation for the admission of a new resident should begin prior to the actual date of admission. If a hospital or community worker was responsible for the initial assessment and screening procedures, the facility worker must obtain this assessment data. This information is essential if the worker, in cooperation with relevant facility staff is to develop a comprehensive treatment plan, and decide on a suitable placement within the facility. If the new resident is to share a room, consideration must be given to the suitable matching of roommates which takes into consideration the need and personal characteristics of each individual.

In reality, assessment information is often unavailable to the facility staff prior to the resident's admission; and the new resident is placed in the only available bed. This often results in additional room changes at a later date, leading to further disruption and stress for the new resident.

When the residential worker has confirmed that admission is pending, an inter-disciplinary staff conference should be held including representatives from the nursing, recreation, rehabilitation, dietetic and housekeeping staff. The goals of this conference are to review the new resident's medical and social history, and utilizing this information develop a cooperative and integrated treatment plan. The primary goal of the worker at this time should be to present a social history that incorporates both the complexity and individuality of the new resident.

One researcher, Kahana (1973), in a study of residential homes has noted that institutional staff tend to view the new resident as someone who for all practical purposes has been cut off from the past. When elderly residents were asked for a self-description, they characterized themselves in terms of their previous social roles. In contrast, descriptions by residential staff were restricted to an appraisal of the residents' physical status or manageability in the home. ("She's a diabetic". or "She doesn't give us any trouble") As Kahana has noted: "...if communication is to occur between the elderly resident and those in the institution who are entrusted with his care, it appears most desirable that there should be some common ground between the way that the elderly person view himself and the way that he is viewed by those who care for him." (p. 283)

If the new resident is to share a room the present occupant should be prepared, and relevant aspects of the new resident's social history should be shared.

When the date of admission has been established, the new resident is notified, and when necessary arrangements should be made for transportation and the transfer of personal belongings. If a community worker has been working with the elderly person prior to admission, she is notified. When possible, the community worker should maintain contact for a period of time following admission. She can provide some sense of continuity and stability during this period of profound change.

During the first few days of admission, one consistent person should be available to assist with unpacking and to provide the necessary emotional support and orientation to the facility setting, staff and activities. This service can be provided by the worker, a staff member, a volunteer, or a resident. Some institutions have established a resident welcoming committee. (Friedman, 1975) Such a committee can benefit not only the new resident, but also the committee members themselves. In addition to providing peer support for the newly admitted resident, it provides an opportunity for purposeful volunteer activity for the established residents.

All staff members should be aware that the new resident will probably arrive at the institution physically and emotionally exhausted. The individual pace of the resident must be respected. While some new residents may thrive on an immediate introduction into the activities of the institution, the majority will require an extended period to incorporate the many changes they are experiencing.

If family members are available to the new resident, they can be actively involved during this phase of relocation. Studies have shown that family members are a valuable resource following admission; and they carry a significant role in providing emotional support, a sense of continuity with the past, and an active link with the community. (Miller & Beer, 1977), (York & Caslyn, 1977), (Smith & Bengtson, 1979)

Family members may display a natural anxiety during

this period of adjustment. If the aging parent's initial response to admission is one of anger, agitation, confusion or depression, the family may experience feelings of anxiety and guilt which may result in futile attempts to compensate through overly solicitous behavior or excessive demands on facility staff.

Adult children can be helped to recognize that the elderly parent's reactions, (which can be attributed to physiological changes, environmental stress, and the dynamics of loss), are not unnatural, deliberate, or necessarily permanent. Timely intervention during this period can prevent family problems from becoming firmly entrenched, and support the family's continued involvement.

Dye and Richards (1980), have described the value of family groups in facilitating the transition to an institution. These groups contained both new residents and those family members who were most important in making the decision for placement. The groups included no more than five family units, and were time-limited. Group discussion centered on the participant's feelings and concerns about placement; and sharing solutions to some of the problems that arose in the institution. The groups appeared to successfully promote both mutual understanding and support.

THE PHASE OF ADAPTATION

Within a period of several weeks the initial impact of relocation diminishes and a period of adaptation to institutional life begins. The advantages of institutional living are

weighed against the disadvantages, and some accommodation is
sought.

The benefits of institutional living, (maintenance of
health and functional capacity, activities, people), are
balanced against the loss of independence and familiar
environmental and social supports. Typically, the resident's
response is ambivalent. "I needed the care,...but there aren't
many people around here like me." "There's some good and some
bad things...I'll suffer along here...but, I do miss my in-
dependence". (Hanvey & McLachlan, 1981)

The need for physical care has been met, but not without
considerable personal and social cost. The price has been
the freedom to structure his own days, to maintain his
privacy, to choose whom to share his life space with. The
cost has included segregation from community, family and
friends; and the loss of familiar roles and activities. Are
these costs an inevitable component of institutional living,
or can they be eliminated or reduced by an institutional
environment that attempts to meet both physical and social
needs.

Tobin and Lieberman (1976), have noted: "The loss of
physical or psychological self-sufficiency does not auto-
matically mean the loss of social needs, the satisfaction
of what can be distinctly therapeutic. The consequences will
indeed be dire if we retreat to "warehousing" these most
needy elderly and do not make every effort to provide life-
sustaining social as well as physical supports." (p. 238)

During this final relocation phase the institutional environment itself becomes a critical factor in achieving successful adjustment. Can we define the dimensions of the institutional environment which might promote or undermine adjustment? Is it a function of the physical setting, the policies and regulations, the programs and services, or the characteristics of the staff?

A number of researchers have attempted to define the salient dimensions of a therapeutic environment. Pincus (1976), has identified four such dimensions: a public-private dimension which refers to the degree to which the environment permits the resident to establish a private area free from institutional transgression; a structured-unstructured dimension which refers to the degree to which the resident must adjust to institutional rules and discipline, or may exert personal choice; a resource sparse-resource rich dimension which refers to the degree to which the environment provides opportunity to engage in activities and social interaction with staff and other residents; and an isolated-integrated dimension which refers to the degree to which the institution affords opportunity for interaction and integration into the outside community.

Moos et al (1979), have developed a Sheltered Care Environmental Scale (SCES), which attempts to operationalize a number of these dimensions. These researchers suggest that this scale should be used by residents and staff to define the type of social and organizational environment they

now have, (noting discrepencies between staff/resident perceptions of that environment), in order to identify and implement possible changes that would improve the social climate. SCES is composed of seven subscales which assess: 1) cohesion - how helpful and supportive staff and residents are with each other; 2) conflict - the extent to which residents express anger and are critical of each other and of the facility; 3) independence - how self-sufficient residents are encouraged to be in their personal affairs, and how much responsibility and self-direction they are encouraged to exercise; 4) self-exploration - how the environment encourages residents to openly discuss their feelings and concerns; 5) organization - how important order and regularity are in the institution, and the explicitness of the rules and procedures; 6) resident influence - the extent to which residents can influence and change the rules and policies; and 7) physical comfort - the degree to which comfort, privacy, pleasant decor and sensory satisfaction are provided by the physical environment. (p. 76)

Implicit in the utilization of these scales is the assumption that the residents themselves must be involved in defining and creating the "ideal" or therapeutic environment. It is the residents' self-perception of the environment, and the degree of congruence between the environmental resources and individual need that are the significant factors. Recognizing the global dimensions of a therapeutic environment, (the opportunity for socialization and privacy, personal

autonomy and choice), is not sufficient. Means must be found
to individualize these dimensions for specific residents taking
into consideration their particular characteristics, background,
needs and physiological deficits.

It is helpful for institutional staff to ask themselves
the following sorts of questions. When institutional activities
are provided, has consideration been given to those residents
who are blind, or bed-ridden? A residential committee is an
admirable vehicle for registering resident complaints, but
can provision be made to reach for the concerns or needs of
the fearful or retiring resident who would not be part of
such a committee? Can we make provisions to protect the
personal safety of the confused or disoriented resident, while
still protecting their personal autonomy?

With a focus on individual need, the type of environment
that facilitates adaptation following relocation might more
aptly be called a "humane environment" rather than a thera-
peutic environment. The residents' capacity to achieve a
successful adjustment may well depend on the extent to which
institutional staff can look beyond disability, diminished
function, and illness and see a person. (Kahana, 1973)

Without negating the significance of the physical setting,
its primarily people who create and sustain the humane environ-
ment, - staff, residents, families, volunteers and society
itself. Each have a role to play.

The health and social needs of individual residents
cannot be met unless the quality and training of staff are

primary administrative considerations. The vast majority of institutions today do little more than provide custodial care: institutions providing social, recreation and rehabilitation services are the exception rather than the rule.

Studies have found that nurses aides perform services with residents about four times as often as members of the professional staff, usually without benefit of pre-employment or in-service training. (Handschu, 1973) While there is often conscientious attention to the physical needs of residents, this contrasts markedly with the lack of attention given to the residents' psychosocial needs. This seldom reflects a callous lack of interest or concern. It is more often a function of inadequate staffing, lack of training and mis-directed operational efficiency. One researcher has written: "The staff realized that they were a centre of human warmth and that being allowed to sit near the desk or being allowed to listen to staff conversation was a comfort for many patients. The more competent elderly managed their own networks of elderly friends, the less competent clung to the nurses...". (Putnam, 1973)

When the institution does have a social worker on staff, one of her primary tasks should be to promote and participate in in-service training of other personnel, with the focus being ways to meet the residents' psychosocial needs.

Residents can be a source of service, comfort and support to each other. However, the opportunity for socialization, the privacy for shared confidences depends to a large extent on

the physical setting and the attitudes of the institutional
staff. The following quote will illustrate:

"I think the staff regarded conversation between patients
as silly and meaningless because they believed the patients
incapable of thought...I saw on more than one occassion,
patients arbitrarily separated in the middle of a quiet chat.
I observed two old women, moved, perhaps, by a dim memory of
time spent with friends long ago, begin to talk as they waited
to have their hair done. One of them suddenly told she would
have to wait until next week and wheeled, still in mid-
sentence, to her room. There was no apparent malice in the
aide's action; she seemed to be enforcing some unwritten rule,
responding to an institutional credo that said patients mustn't
chat. (Curtin, 1972, p. 151)

Institutions can provide the climate in which friendships
can flourish: through activity programs that draw residents
together; small group programs that foster intimacy and sharing;
resident volunteer programs that encourage mutual concern and
support; and residential committees that provide the opport-
unity for a sense of shared community.

Family relationships not only survive institutionalization;
the possibility also exists for renewed and strengthened close-
ness. (Smith & Bengtson, 1979) These two researchers examined
family relationships from the perspective of both generations
in an institutional setting over a period of two years. Over
half of the families interviewed had experienced a renewal or
continuation of family closeness.

There were several reasons commonly cited for this positive outcome following institutionalization. Prior to admission, a number of these families had invested considerable emotional and physical energy into maintaining the elderly parent in the community. Institutionalization had relieved these families of the physical burden of care, permitting them to focus their energies into providing the necessary emotional support. A second factor was the improvement in the parent's mental or physical state, possibly confirming the family's belief that institutionalization had indeed been necessary and unavoidable. A final factor was the parent's involvement with other residents, which in turn relieved family members of the necessity to supply all the parent's social and emotional needs.

Other studies support this evidence that families do maintain the patterns of involvement that they had established before placement. (Miller & Beer, 1977), (York & Caslyn, 1977) However, families require support in maintaining these ties. Institutions can develop programs that incorporate family members into the institutional setting. These include: orientation programs; educational programs on the process of aging, and on ways in which families can continue to give care to their parents; volunteer activities; and programs to mark holidays or special family occassions. The role of the institution can expand to include services for the family as well as for aging parent.

In the absence of family ties, volunteer participation in institutional programs can provide much needed companion-

ship and association with the outside community. In addition, volunteers can serve a watchdog function, monitoring the quality of institutional care. Volunteer activities require the direction and support of institutional staff. A worker must be available to provide orientation, to develop programs, to supervise the services, and provide emotional support to the volunteers themselves. Without this worker investment, volunteer programs are seldom self-sustaining.

The institution cannot be divorced from the society at large. The quality of care we provide for our aging population reflects our cultural belief about the value of that population. We do not wish to recognize the reality of aging, and our own mortality, and we hide the evidence of that reality behind institutional doors.

> "Until society can say "We are they," things
> will remain much as they are. The old do not
> want outreach, they want association. Even the
> best old people's home is marked by disassocia-
> tion, and the old know it. What they come to
> terms with when they enter these doors is this
> mark of disassociation. It is not always an
> unhappy thing to have written off one's independ-
> ence; often it is a relief. But it is profoundly
> disturbing that by doing so one has severed links
> which held one to the centre, however precariously.
> We have to admit that our own potential agedness
> grows within us as a first step towards destroy-
> ing the isolation of these convenient fastnesses.
> The rest is simply a matter of money and imagin-
> ation, both of which have been in notoriously
> short supply.
>
> (Blythe, 1979, p. 104)

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