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## Risk of Nursing Home Admittance among Working Age Residents with Mental Illness

### Abstract

The number of working age (18-64) nursing home (NH) residents with a mental diagnosis at admission rose from 70,600 in 1997 to 97,200 in 1999 (Jones, 2002). Utilizing the Behavioral Model for Vulnerable Populations (Gelberg, Andersen, & Leak, 2000), I examined factors associated with NH admittance in a sample of working age residents with mental illness. I conducted a qualitative analysis of 20 residents' healthcare and social experiences leading to NH admittance. Data came from semi-structured interviews, medical records, and clinicians. Results showed that homelessness, drug abuse, and low functional status were perceived by residents to play a role in their admittance. Overall, participants associated disadvantaged social and healthcare experiences with current NH admittance.

### Keywords

Nursing Home Admittance, Mental Illness, Drug Abuse, and Homelessness

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## **Risk of Nursing Home Admittance among Working Age Residents with Mental Illness**

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*The number of working age (18-64) nursing home (NH) residents with a mental diagnosis at admission rose from 70,600 in 1997 to 97,200 in 1999 (Jones, 2002). Utilizing the Behavioral Model for Vulnerable Populations (Gelberg, Andersen, & Leak, 2000), I examined factors associated with NH admittance in a sample of working age residents with mental illness. I conducted a qualitative analysis of 20 residents' healthcare and social experiences leading to NH admittance. Data came from semi-structured interviews, medical records, and clinicians. Results showed that homelessness, drug abuse, and low functional status were perceived by residents to play a role in their admittance. Overall, participants associated disadvantaged social and healthcare experiences with current NH admittance. Key Words: Nursing Home Admittance, Mental Illness, Drug Abuse, and Homelessness*

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An individual's risk of nursing home placement over his or her lifetime is considerable. Several studies have explored factors which impact this risk over the life course. Factors such as "inadequacy—in finances, health, social supports, emotional strength, or other abilities to cope" (Smallegan, 1985, p. 364) have been linked to nursing home admittance (Miller & Weinstein, 2002; Schoenman, 1995). Also, factors such as functional and cognitive impairments, along with increasing age, and living alone, are associated with enhanced risk of institutionalization (Branch & Jette, 1982; Green & Ondrich, 1990).

Although nursing home use is typically associated with the elderly, a substantial number of working age (18-64) individuals are at risk. The National Nursing Home Survey showed that 158,700 people, or 9.7% of all nursing home residents, were under age 65 in 1999 (Jones, 2002). Many of these working age nursing home residents suffered from mental illness. The number of working age nursing home residents nationwide with a diagnosis of mental disorder at admission rose from 70,600 in 1997 to 97,200 in 1999. In a study of 205 working age nursing home residents in Maryland, it was found that almost half (44.4%) of the sample had a prior or current mental health condition (Miller & Weinstein, 2002)

In a study comparing a sample of working age individuals living in the community to those in institutions, such as nursing home facilities, it was found that those in institutions tended to be more functionally impaired than individuals living in the community (Schoenman, 1995). In addition to functional status, enabling factors such as knowledge of available community options, few support mechanisms, "fear of community living and level of desired autonomy in planning one's life" (Depoy & Werrbach, 1996, p. 24) were also significant factors (Tate, Maynard, & Forcheimer, 1992).

Social support also plays a major role in nursing home admittance among working age individuals (Biegel, Sales, & Schulz, 1991). Social support includes psychosocial resources such as coping mechanisms and personal and family resources such as accessibility to needed information and services in the community. Data indicate that a major factor increasing a person's chance of nursing home admission is living alone (Foley, Ostfeld, Branch, Wallace, McGloin, & Cornoni-Huntley, 1992; Kelman & Thomas, 1990; Shapiro & Tate, 1985). This is evident in Depoy and Werrbach's (1996) study where individuals attributed their ability to live in the community to the availability of assistance from relatives and friends. Studies also show that when a spouse is caretaker, the risk of institutionalization is lessened (Donohoe, Wineman, & O'Brien, 1996; Fiore, Becker, & Coppel, 1983; Miller & Weinstein, 2002; Schoenman, 1995).

Low socioeconomic status also places individuals at increased risk of nursing home admittance (Foley et al., 1992; Miller & Weinstein, 2002). In Miller and Weinstein's study of working age residents, the primary source of income for 38% of the respondents was Supplemental Security Income (SSI), 28.9% reported no income at the time of admission to a nursing home, and over 80% of the sample had an approximate yearly income between \$0 and \$14,000. A similar profile was found in Foley et al.'s study, which indicated that the use of nursing homes was highest among those with incomes less than \$5,000 per year.

Such findings suggest a variety of factors, including low socio-economic status (SES), lack of social support, low functional ability, and mental health concerns, are interacting to make nursing home placement a viable option among working age individuals. To further explore this issue, the Behavioral Model for Vulnerable Populations (Gelberg et al., 2000) was used to assess the role of such factors in nursing home admittance among working age individuals with mental illness. This model provides a framework for understanding health care service utilization and health outcomes among vulnerable populations (i.e., mentally ill, poor, homeless persons). In this study, vulnerability is defined as factors that place an individual at higher risk of disease and injury due to challenges (e.g., socioeconomic) hindering one from obtaining needed healthcare services (Gelberg et al.). Groups often experiencing vulnerability include minorities, homeless individuals, persons with mental illness, those with chronic illnesses, the impoverished, and disabled persons. In this study, I examined residents' conceptualizations of the factors associated with their nursing home admittance. Attention was given to those social and healthcare factors which they felt placed them at greater risk or vulnerability to nursing home admittance.

### **Research Questions**

- (1) How did residents conceptualize the reasons for their current nursing home admittance?
- (2) What role did vulnerability factors<sup>1</sup> (such as mental illness, drug use, residential history, etc.) play in residents' conceptualization of the reasons for their nursing home admittance?

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<sup>1</sup> Vulnerability factors- Factors indicated in the theoretical model that can place you at increased risk of negative health outcomes.

## **Researcher Context**

I, the author, am a recent graduate of a doctoral program in Health Policy. As a Ph.D. student and part-time research assistant, I worked on several research projects dealing with long term health care issues, specifically, nursing home admittance among working age individuals. In my work as a research assistant, I conducted research dealing with working age nursing home residents and their involvement in nursing home admission decisions. I also examined the roles and perceptions of providers, patients, and family members regarding nursing home care decisions. During the course of this research, I found a significant number of working age nursing home residents suffering from mental illness. I became very interested in discovering the reasons why such a large proportion of working age nursing home residents had a history of mental illness. Thus, this became the subject of my dissertation research, which is described in this paper. The results show there were a multitude of factors (i.e., social, economic, physical and mental limitations, etc.) impacting the placement of these individuals in nursing homes.

## **Methods**

### **Research Design**

A mixed methods approach, one that includes both quantitative and qualitative techniques, was utilized in this study to examine the life experiences of a sample of working age nursing home residents with mental illness. According to Greene, Caracelli, and Graham (1989), a research design incorporating multiple methods can enhance the quality and scope of study results. A mixed methods approach was used in this study to accomplish the following three goals: (a) to explore the consistency of results from qualitative and quantitative methods, also called triangulation; (b) to clarify findings from one technique with the use of other techniques, or complementarity; and (c) to enhance the depth and quality of the data by examining features of multiple techniques, or expansion (Greene et al.).

Through this research, the objective is to: (a) understand the manner in which participants conceptualize the reasons for their nursing home admittance, outside the framework of the Behavioral model (as evidenced by the first research question and the use of inductive coding); and (b) explore the role variables in the Behavioral model may play in explaining the reasons for nursing home admittance in this sample (as evidenced by the second research question and the use of deductive coding). The results of each technique are intended to inform one another in order to obtain a clearer understanding of the complex issues impacting the residents, and are not meant as a source of comparative analysis between the two techniques. Ultimately, through this mixed methods approach, the purpose is to understand the manner in which risk of nursing home admittance was conceptualized by residents, while also examining how concepts in the Behavioral model could be used to describe nursing home admittance in this sample.

Using this mixed methods approach, I explored how factors such as socioeconomic status, environmental conditions, and access to health care services were conceptualized by participants, whether participants perceived them to affect their current health condition, and specifically whether they perceived them to play a role in their

nursing home admittance. Through in-depth discussions concerning patients' past and current experiences within the health care system, as well as social and economic experiences during the period preceding nursing home admittance, information was gathered to depict the reasons for nursing home admittance in the study population. Particular attention was given to participant perceptions of their experiences occurring during the period immediately prior to nursing home admittance.

**Behavioral model.** The Behavioral Model for Vulnerable Populations (Gelberg et al., 2000) was utilized to provide a framework for understanding nursing home admittance in this population. The model was derived from Andersen's Behavioral Model of Health Services Use (1968) which was developed to determine what impacted a person's health care utilization patterns. The model proposed that utilization was impacted by a person's predisposition to use services, aspects that enabled or impeded utilization, and a person's health care need (Andersen, 1968, 1995). When the Behavioral model (Anderson, 1968) was derived, the emphasis was mainly on individual level factors which impacted the use of health care services. However, over the years, the model has been broadened to cover four areas of interest: (a) health outcomes, (b) utilization of health care services, (c) individual characteristics, and (d) environmental influences (Andersen, 1968, 1995). The health outcomes component includes factors such as, clinical assessments of health, as well as a person's perception of their health, and satisfaction with their care. The health care services component accounts for an individual's personal health practices such as exercise, self-care, adherence to care, and diet. Individual characteristics include various social and demographic characteristics such as age, gender, ethnicity, and marital status. Such factors often predispose an individual to use services (i.e., health service use declines with less education). Lastly, environmental factors such as violence and poverty impact an individual's health and his/her use of health care services.

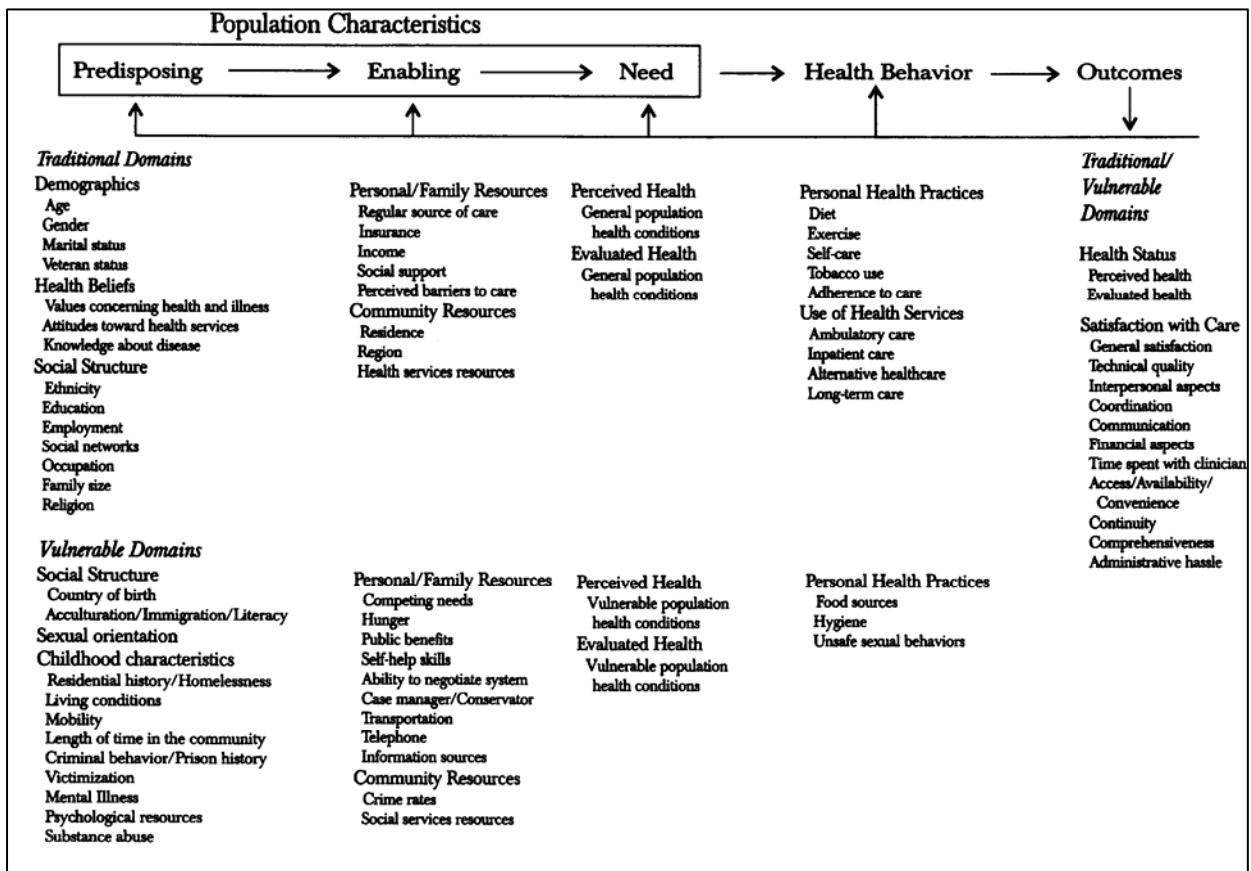
The original model has been revised and expanded to apply to vulnerable populations (Gelberg et al., 2000). It was believed that the Behavioral Model for Vulnerable Populations was needed because those aspects which make a population vulnerable may impact its health outcomes and utilization of health care services. Consequently, the revised model accounts for factors that must be considered when examining health status and service use among vulnerable populations. This model allows for the assessment of how use impacts health outcomes. Therefore, health status is a determinant of utilization in addition to being an outcome variable.

Additionally, the Behavioral Model for Vulnerable Populations incorporates both traditional and vulnerable domains. The vulnerable domain, which focuses on social structure and enabling resources, was included to provide information relevant to vulnerable groups. The traditional pre-disposing domain includes factors such as age, gender, and marital status; the vulnerable predisposing domain takes into account factors such as substance abuse, childhood characteristics, living conditions, and criminal behavior.

The enabling traditional domain accounts for personal/family resources such as income, insurance, and regular source of care, as well as community resources such as health services resources and residence. The enabling vulnerable domain accounts for personal/family resources such as public benefits and the availability and utilization of

information. Community resources include the availability of needed social services and rates of criminal activity within the community. The traditional domain of need includes factors such as evaluated and perceived need, where as the vulnerable domain of need includes evaluated and perceived need concerning ailments of particular relevance to vulnerable populations such as mental illness, substance abuse, and HIV/AIDS. The personal health practices traditional domain includes factors such as self care, exercise, and diet, and the personal health practices vulnerable domain accounts for unsafe sexual behaviors, hygiene, and food sources. The outcomes domain goes beyond the traditional and vulnerable domains, taking into account satisfaction with care, along with perceived and evaluated health status. See Chart A for a detailed description of the Behavioral model.

Chart A. The Behavioral Model for Vulnerable Populations<sup>2</sup>



<sup>2</sup> Gelberg, L., Andersen, R. M., & Leake, B. D. (2000). The behavioral model for vulnerable populations: Application to medical care use and outcomes. *Health Services Research, 34*(6), 1273-1302.

**Study sample.** A convenience sample of nursing homes was used in this study. A sample of nursing homes was identified from a state website listing all nursing home facilities in the state of Maryland. Nursing home officials were contacted and asked to participate in the study. The five facilities utilized in the study were the first of the contacted nursing homes to agree to allow recruitment efforts in their facility. Study participants were recruited from a total of five facilities selected from two counties and four cities in Maryland. The sample included one nursing home facility located in an inner city community while the others were located in suburban areas. The sample of working age nursing home residents consisted of 20 individuals of working age, with a primary or secondary diagnosis of mental illness. Diagnosis was determined through medical records and referral information from nursing home social workers. Demographic information, medical diagnoses, and functional status were examined utilizing existing medical records, only with participant permission.

The majority of the participants were African American (15), and five were Caucasian American. Over half of the sample was male (13) and seven were female. The age of the participants ranged from 27 to 55, with a mean age of 43.3. A significant proportion of the sample had (11) received a high school diploma or GED. Most of the respondents were currently single (17), and of the three married respondents, all were currently separated. Most study participants (11) had never been married. The majority (14) of the residents were currently dependent upon SSI/SSDI for monthly income, 19 residents made less than \$15,000 per year, and five had no source of income.

The sample had a variety of mental diagnoses, with 14 suffering from depression, five with anxiety disorder, and six diagnosed with psychosis and/or psychotic disorder. Other mental conditions included: obsessive-compulsive disorder (2), paranoid schizophrenia and/or schizoaffective disorder (3), bipolar disorder (2), and personality disorder (1). Residents often had multiple overlapping diagnoses, and medical record data often failed to distinguish between primary and secondary conditions. Half of the respondents (10) had co-occurring substance abuse problems, as well as various physical ailments such as HIV/AIDS (6), diabetes (5), and seizure disorder (5). Respondents varied in terms of their functional status. Five respondents were able to perform all specified Activities of Daily Living (ADLs), physical and mental daily tasks such as bathing, dressing, and using the telephone, that are used to measure functional status. Ten respondents had difficulty performing 1-5 ADLs and four respondents had difficulty performing 6-13 ADLs.

## **Data Collection**

**Interview protocol.** University of Maryland, Baltimore County (UMBC) IRB approval was obtained, and all appropriate review procedures were undertaken. Nursing home social workers were consulted to ensure cognitive ability of the residents prior to their participation in the study. The interviews took place in a private location such as participants' room or an office within the nursing home. Prior to the start of the interviews, participants had to sign a consent form indicating that they were informed about the details of the study and that they agreed to participate.

The interview protocol consisted of several components: (a) a cognitive ability test, (b) a pre-screening tool, and (c) open ended interview questions. Cognitive ability



was judged by questioning residents about their understanding of the study as well as asking standard orientation questions derived from the Mini Mental State Examination (MMSE; Folstein, Folstein, & McHugh, 1975). Residents then completed a pre-screening tool in which the interviewer read a list of health conditions (i.e., diabetes, kidney disease, cancer, etc.), including mental illness, and asked if the patient currently or previously had been diagnosed with the condition. The purpose was to further assess residents' history of mental illness. Then the interview took place, lasting approximately 1 to 1 ½ hours. Interviews were conducted and audio-taped with participant permission. Questions were open-ended and notes detailing the interviewees' responses were taken throughout the interview.

**Interview questions.** The interview questions covered six major content areas: (a) Individual and Social Factors, (b) Nursing Home Admittance, (c) Health Condition, (d) Mental Health Condition, (e) Health Service Use, and (f) Mental Health Service Use. Questions were designed to obtain a general overview of participants' life experiences from childhood to adulthood, with emphasis on their history of health care service use and health conditions. Generally, questions were derived from concepts taken from the literature and were not modeled after an existing instrument—with the exception of the functional status scales (e.g., ADLs and instrumental activities of daily living [IADLs]).

Individual and Social Factors questions consisted of information about each participant's overall social environment, including his/her place of birth, ethnicity, educational experiences, relationships, and job experiences. Various probes were used throughout the discussion to gain a better understanding of participants' social experiences from childhood through adulthood.

The respondent's current health condition was indicated by medical record data as well as by participant recall. If there was a discrepancy in sources, more weight was given to medical record data. Probes were used to examine when the illness occurred and the extent of the condition. When interviewees failed to mention their mental health condition, probes were used to determine when, and by whom, respondents were diagnosed with a mental illness. Respondents were then questioned about where they usually go to receive their mental health care in efforts to determine participants' level of contact with a mental health professional (i.e., psychiatrist, psychologist, mental health worker) currently and/or in the past. Also, to determine general health care service use patterns, interviewees were asked where they normally receive care. Information about whether respondents received regular care, the types of services they had received in the past, and whether they had any difficulty receiving care, was gathered.

In order to determine participants' levels of functioning, questions were asked about their ability to perform various physical and mental daily tasks, or ADLs. Level of functioning was assessed through counting the number of ADLs the respondent was unable to perform without assistance. The questions used to determine functional ability in this study were derived from Katz, Ford, Moskowitz, Jackson, and Jaffe's (1963) Activities of Daily Living Scale and Lawton and Brody's (1969) Instrumental Activities of Daily Living Scale.

Discussions specifically about the interviewees' current nursing home admittance began with the question, "In your own words, tell me why you feel you're here in a nursing home at this point in your life?" Probing questions were used to determine where

they lived and what events took place directly prior to the nursing home admittance. Responses were utilized to determine the reasons for admittance, parties involved in the decision making process, and participant preferences regarding placement options. Efforts were also made to gain information about prior nursing home placements and their current length of stay.

A variable of importance when examining the impact of disadvantage and vulnerability on nursing home admittance was the presence of social support mechanisms and resources. Social support, in this study, was defined as the assistance and emotional encouragement that individuals received from their social networks and environment. To ascertain participants' perceptions of the level of social support available to them (perceived support), the following question was asked: "Tell me about where or to whom you feel you can turn to in order to get help (i.e., money, advice, or encouragement) when you need it..." Probing questions were used to determine how close the participants were to identified parties, how often they were in contact, and the kind and level of support generally received from these individuals. When discussing their admission to the nursing home, participants were also asked whether anyone in their social network was involved in the admission decision.

## **Data Analysis**

In this study, data from audiotapes were transcribed and notes detailing the interviewee's response to questions were taken during the interview. These notes were used only to validate taped responses or provide clarity when responses were inaudible. Codes were given to sets of words used by interviewees, and codes were modified into relevant themes. Inductive and deductive coding was conducted.

Firstly, inductive coding was conducted to show how risk of nursing home admittance was conceptualized solely by participants. Deductive coding was then used to display nursing home admission within the parameters of the Behavioral Model. There was no systematic comparison of the results from the two coding systems. Instead, the results were meant to inform each other and ultimately enhance the richness and quality of the data through the use of both qualitative and quantitative methods. Through this approach, the study gains the benefits of both techniques, a deeper understanding of the world through the participant's eyes, and an examination of the participant's experiences through the structure of the Behavioral model.

Inductive coding was conducted through clustering; a process of constructing categories and then sorting information into those categories. In this instance, we conducted a thorough assessment of the data, involving a review of the words used throughout the typed transcripts, in order to identify the dimensions or themes that seemed particularly meaningful to the participants. All strings of words repeated most frequently throughout respondent interviews and across respondents were considered most important and were used to form overarching categories.) All strings of words relevant to those concepts were then grouped together. Data were separated by similarities and associations between concepts, and were categorized according to the patterns and relationships found. These patterns were then used to examine the research questions, results were compared to previous research, and subsequent conclusions were made. Data patterns were discovered and involved continuous refinement throughout the

data collection and analysis process (Glaser & Strauss, 1967). This entailed recording observations for one participant followed by coding and analysis, followed again by observation of another participant, coding and analysis and so forth to ensure continuous refinement of patterns throughout the process. The inductive coding scheme that resulted from the aggregation of individual coding and analysis procedures following each interview included nine broad categories: negative childhood experiences, positive childhood experiences, adult experiences, social support mechanisms, mental health condition, current outlook, life prior to admittance, physical health condition, and health services use. Efforts were made to ensure all participant responses were taken into account in the inductive analysis. Both quantitative and qualitative methods were utilized to analyze participant responses. In the quantitative analysis, counts of textual elements were used to determine the magnitude of importance themes were to respondents, and then those themes were used to shape the inductive results. The following concepts, which were noted by the majority of respondents, were considered major themes: (a) low educational attainment, (b) problems maintaining healthy relationships, (c) non-traditional family structure, (d) major childhood experiences, (e) low functional status, and (f) evidence of social support. See Tables 1 and 2 for illustrations of the data used to develop these categories, taking into account counts of textual elements and the content of participant responses.

Although counting helped determine the type of information collected and assisted in specifying concepts which were meaningful to participants, in the qualitative analysis it was more important to consider the actual words in the text being analyzed, including the way these words were utilized to ensure the exploration of both manifest (i.e., countable elements) and latent content (i.e., meaning attached to participant responses; Berg, 2001). Particular attention was given to depicting each individual's experience and relating it to health outcomes in a way conceptualized by the interviewee. Thus, statements from respondents were given in their context, paying close attention to how they were used to respond to questions. For example, instead of simply stating that the respondent had problematic relationships, an explanation of the reasons, from the respondent's view, were given such as, "I never learned social skills growing up." Another example is not simply stating the theme of poor education, but providing respondents' views of the reasons or context of the action resulting in poor education such as, pregnancy or parental neglect.

Deductive coding involved the use of a categorical scheme based on the predisposing, enabling, and need factors of the Behavioral Model for Vulnerable Populations. Data were arranged into several categories in an effort to observe their relation to the Model: (a) Predisposing factors, (b) Enabling factors, and (c) Need factors. Typed transcripts were reviewed for strings of words that matched variables specified in the model for predisposing (i.e., criminal behavior), enabling (i.e., competing needs), and health care need (i.e., personal health practices). All strings of words that were relevant to each category were grouped together and used to answer the research questions.

**Reliability and validity.** To ensure rigid and consistent application of categorization techniques and reliability of measures and valid findings (Berg, 2001; Yin, 1994), data were examined in terms of the behavioral model, and both quantitative and qualitative techniques of content analysis as described above. Data quality was also

assessed through checking for outliers, and looking for negative evidence. Efforts were made to examine those cases which differed substantially from the group to determine the unique circumstances leading to their nursing home admittance, as well as observing commonalities (Marshall & Rossman, 1999). For example, although the majority of cases described some type of trauma that occurred early in childhood (i.e., parental neglect, criminal activity), a few respondents noted that they had the “perfect childhood.” These cases were examined to determine if there were similarities or unique factors associated with their admittance. The process of data triangulation (Yin) was used in this study to establish converging lines of inquiry. Both medical records were obtained with participant permission (n=14) and interviews were conducted (n=20). These two components provided multiple measures of the same phenomenon, therefore, enhancing construct validity. In situations where the two differed, particularly in terms of diagnosis, greater weight was given to medical information due to the mental status of the respondents. Nursing home social workers were also used to verify information as needed.

Efforts were also made to ensure that the data collection methods followed the procedures stipulated in the protocol, and that there was a link between the content of the protocol or proposal and the study questions. Reliability was further maintained by adequate documentation of the procedures followed in every case (e.g., interview time and place). Case study data included typed interview transcripts and coding outlines, enhancing the reliability of the overall design of the case study (Yin, 1994). Reliability was enhanced by ensuring adequate documentation of the procedures used, in case the study was replicated. In order to further increase construct validity, the instrument used in the study was reviewed by key informants who had a working knowledge of the population under study, including officials at the nursing home (e.g., social workers, nurses). Academic researchers who had conducted studies on individuals with mental illness and nursing home resident populations, and counselors at a non-profit community based organization specializing in providing services to such groups, also reviewed the study protocol and provided comments on needed changes to the structure and composition of questions and the quality of the study protocol prior to the start of the study.

## **Results**

### **Inductive Analysis**

**Low educational attainment.** A theme that emerged several times throughout respondents’ conversations was that of failed educational pursuits and its impact on their current health outcomes. Most of the respondents (11) dropped out of high school at an early age, with nine failing to receive either a GED or high school diploma. Several of the residents proceeded through most of their schooling and dropped out in the last two years of high school, usually between the 10th and 12th grades. This is evidenced by Lorie, who noted that she “went to the 12th [but]...didn’t graduate.” Only four participants in the sample attended college, and only one respondent graduated from college.

Residents had various reasons for failing to finish school. Several of the respondents mention teenage pregnancy as a factor impacting their educational attainment. Jeffrey mentions that he “got to the 12th grade and ...had six credits to get but [he] had a son... So, [he] dropped out to take care of him and...just got a job.” Karen, who claims she was left to raise herself at the age of 14 because of her mother’s drug abuse, notes that after living “...with men after men after men ... [she] got pregnant at 17 and...had to quit school...in the 10th grade.”

Some of the residents place much of the blame for their lack of education on their parents. Sarah contends that from an early age, she “only went to school when [she] was sent” and that was a rarity. She claimed that she was neglected and left to raise herself from a very young age. She further claimed her feelings about being neglected led to a string of rebellious behaviors during her adolescence. She stated that:

I guess I just kind of rebelled really bad...I really became wild...I did everything and anything to make [mom] mad...and I did anything to get out of that house.

As a strategy for getting out of the house, at the age of 14 she got pregnant, dropped out of high school, left home, and got married. Looking back at that time in her life, she notes, emphatically, that she “couldn’t wait to get out of [her] parents’ house” and she would do anything to achieve that goal. Similarly, other residents blame their failure to finish school on negative experiences with their parents. Isaiah states that, his “...mother and father got divorced around the time that [he] was really...supposed to be getting involved in school, and it really threw [him] off track... and [he] started taking off and skipping school with friends....” He later became involved in criminal activity and ended up doing five years in prison for burglary. He never made it past the 10th grade.

Involvement in criminal activity was a common factor affecting educational attainment in residents. Isaiah felt that his failure to finish high school was the start of a string of problems in his life. According to him, “I think...my problems came when I didn’t finish school.” He speaks of involvement in criminal activity at times when he was supposed to be in school:

My sister’s boyfriend used to take me and my little buddy out—we used to go out and case homes and uh, we started burglarizing homes when we was real young...when we was supposed to be in school.

Similarly, Jeffrey mentions that he got so involved in the street life once he dropped out of high school, that education became increasingly less of a focus. He notes that, “I guess I wanted to experience the streets...the street life. So, I really didn’t try to pursue the GED after high school.” He contends that his rebellious behaviors began when he was forced to leave his mother at a young age and move in with his father. He states that “...acting out was just my way of saying that I’m not happy with the situation that was at hand.” See Table 1 below for examples of respondents’ views regarding educational attainment.

*Table 1.* Number and content of responses regarding factors impacting low educational attainment, n=20

<b>Factors Impacting Low Educational Attainment</b>	<b>Examples of Respondent Quotes</b>
<b>Teenage pregnancy (3 Residents)</b>	"I got to the 12th grade and ...had six credits to get but I had a son... So, I dropped out to take care of him and...just got a job".
<b>Parental neglect (6 Residents)</b>	"I only went to school when I was sent..."
<b>Criminal activity/street life (6 Residents)</b>	"My sister's boyfriend used to take me and my little buddy out—we used to go out and case homes and uh, we started burglarizing homes when we were real young...when we were supposed to be in school".
<b>Rebellious behavior (3 Residents)</b>	"I guess I just kind of rebelled really bad...I really became wild...I did everything and anything to make [mom] mad...and I did anything to get out of that house."
<b>Parental separation/divorce (12 Residents)</b>	"My mother and father got divorced around the time that I was really...supposed to be getting involved in school, and it really threw me off track... and I started taking off and skipping school with friends..."

**Problems maintaining healthy relationships.** In this study, many residents spoke about having problems maintaining relationships. Among all of the respondents, nine had been married at some point in their lives. Of these nine individuals, four had received a divorce and three were separated at the time of the interview. Over half of the sample (11) had never been married and two were widowed. Among those who had never married, there were mixed views about the concept of marriage. Some were extremely against the prospect of marriage, as noted by George who emphatically stated that he had never been married and "Never will!" Others spoke highly of marriage and felt that all individuals desired to find "...that somebody that you feel you're good with."

Some of the residents had been in several unsuccessful relationships throughout their lives. When Nathan was asked about his experiences, he described his adulthood as a series of "ups and downs," primarily due to the ending of his first marriage. Some of the residents who had married only once, never ventured into marriage again after the first time. Sarah notes that her marriage "...lasted about a year and a half...it ended in divorce...and [she] never married again." Other respondents noted that they had been married multiple times, as evidenced by Mary who casually mentioned she had been "...married three times...and that [her] third husband just died in November." Although, more information is needed to determine the reasons for these break ups, such comments mirror results found in the literature that suggest a greater number of failed relationships among people with mental illness, compared to the general population. Some researchers purport that marital status is a determinant of mental health (Horwitz & Scheid, 1999)

while others believe that an individual's mental disorder impacts her/his likelihood of becoming married and maintaining a marital relationship (Horwitz & Scheid; Mastekaasa, 1992).

Abusive relationships were also noted in the stories of residents. When describing how the physical abuse started in her nine year relationship, Theresa states that "...six months into the marriage he started hitting and I kept making excuses for him." Although they were still married at the time of the interview, she noted that they had been separated for three years. She recognizes at this point the extent of her denial of the abuse and how it has affected her health. She notes that although she knew her health was ailing, she put other peoples' needs, particularly her husband's, before her own. Similarly, Carrie appeared to minimize the level of abuse that took place in her relationship. She spoke lovingly about her abusive ex-boyfriend. When describing her relationship, she stated that they met on a blind date, and "lived together for 16 years...in *somewhat* of an abusive relationship." She goes on to describe the positive aspects of the relationship, failing to go into detail about the abuse that took place. However, she does acknowledge that her problems with depression stemmed from their separation. She states that:

...[the depression] started about six weeks after I realized that [he] was not coming back to mom's to pick me up ...we separated in 2000, and after that the depression just hit.

Michael was very candid and spoke in depth about the physical and emotional abuse he witnessed in his parents' relationship. In describing his parents' break up, he notes that:

They had a lot of problems, they used to fight...he used to beat on her and then when he left her, seems like he went downhill...

He further states that the physical and emotional abuse in his parents' relationship was fueled by alcohol abuse, a problem which finally took the life of his father.

Through discussions with residents, it became apparent that relationship problems were common not only in male/female contacts, but also in friend and familial interactions. John maintains that he had problems sustaining relationships with all types of individuals. He states that he "...had problems with relationships with people...not necessarily male/female relationships but just relationships in general." He believes his problems stem from never being taught as a child how to maintain healthy relationships. He describes his relationship with his family as he was growing up as "non-existent," and he claims that currently he is not close to anyone in his family. Similarly, Sarah spoke of her estrangement from her family by saying:

I've been shunned all my life... I never was accepted...they don't talk about me much...they swept me under a rug.

She currently has no communication with her family members, primarily due to her current heroin addiction and history of unruly behavior since childhood. Annette sums

up the sentiments of many of the residents as she describes her current situation. She asserts that "...my finances, my health, my relationships, my life...it's just not right."

**Non-traditional family structure.** A common thread linking many of the respondents was the non-traditional structure of their families. Most of the residents grew up in one parent households (12), and were primarily raised by their mothers. Those in one parent households were typically products of divorce and/or separation. According to Theresa who described her parents' relationship, she stated that, "My parents had divorced when I was three years old. So, my mom basically raised us." She notes that there was minimal contact between her and her father over most of her life, a common characteristic among many of the residents. Despite the lack of emotional and financial support from her father, she notes that her mother "...did whatever she had to do to make sure [their] family was happy and well taken care of...."

Another common occurrence among residents was that many were raised by extended family members or relatives such as grandmothers, aunts, and sisters. This occurred among five of the residents, with the majority of them being raised by their grandmothers. Karen notes that she was raised by her grandmother primarily because of her mother's drug addiction. According to her, once her grandmother died, she was left to raise herself. She states that, "...my grandmother practically raised me and when she died I was like 14...I was basically on my own cause my mother had a drug problem too." Much like her mother, she currently suffers from a drug addiction, and she also has several estranged children who were taken from her due to her addiction.

Among those raised by extended family members, it was common for children to be passed around among different relatives. This was particularly evidenced by John who stated that, "I was raised by my mother and grandmother and was passed around to my aunt also." When asked about his relationship with his family growing up, he describes it as "non-existent." He conveys that, as a child he felt unwanted and always felt his family only kept him because they were "responsible" for raising him; not out of a genuine desire to care for him. Similarly, other residents were shuffled between parents and other family members throughout their lives. Many lived with one parent for half of their childhood and the other parent for the later years of their childhood. Jeffrey asserts that, "I was raised by my mother up until the age of three, and uh, my father took over...I went to live with my father for a little while...until age 18." Jeffrey, who suffered from depression and anger problems as a child, blames much of his early problems on his inability to adjust to this new situation. Other residents also lived with their parents for a portion of time, and extended family members for the remaining time. Nathan notes that "my mother raised me part the way...and my grandparents raised me part of the way." Overall, many of the residents tended to have non-traditional family environments which fluctuated often amidst difficult circumstances such as divorce, separation, drug addiction, and neglect.

Although many residents grew up under non-traditional conditions, still six grew up in two parent households. Many of these residents describe their childhood experiences very positively. In describing her childhood, Carrie states that, "Mom and dad and papa and them made my childhood magical." She goes on further to detail how her family members offered a supportive environment which gave her the strength and



tenacity to endure various difficulties throughout her life, particularly those dealing with her disability.

**Childhood experiences.** When asked about their childhood experiences, many of the respondents began by noting fond memories of their youth. Residents spoke of the fun they had “just being around family...growing up, having fun, being a kid.” Residents also mentioned times when they enjoyed going to school, playing games with their friends, and going on trips with family members. For Carrie, the highlight of her “magical” childhood was when she was chosen to be a poster girl for Cerebral Palsy. For Isaiah, his fondest memories were when he and his siblings would go to the country and “get vegetables, have collard greens, and take collard greens and water crests, and pork shallots, and come back and knock on the doors and sell it to [the] neighbors.” Half of the sample noted that the best memories of their childhood involved just being with family. These and many other individuals spoke of the joys of being a child in the midst of harsh and difficult circumstances. Respondents often mentioned being poor as a difficulty while growing up.

Although, most respondents mentioned many positive aspects of childhood, there were also negative experiences noted. Some of the negative themes that emerged from respondents included experiences with discrimination, violence, neglect, drug abuse, poverty, and divorce as a young child. Residents described how these experiences affected their childhood in both positive and negative ways. Specifically, some residents spoke about discriminatory acts directed at them by their peers growing up, while others spoke about their involvement in criminal activity or their witness to violence as a child. When asked about his childhood experiences, George mentions that growing up in New Jersey was “alright,” but shortly afterwards, he noted that “[he] lost one cousin...he got shot in the head over a gold chain and uh some money.” Other respondents spoke about their involvement in various criminal activities as a child. Isaiah mentioned that following the separation of his parents, he became less interested in school and more involved in running the streets. He noted that he “...messed around and got caught up to never finish school but [he] tried to go to summer school and catch up several times...but never really got a chance to really catch up...” Then he ended up in prison for several years, further lessening his chances of getting back on the right track. Three of the residents spent time in detention centers, prisons, and psychiatric institutions as children. Jeffrey noted that due to his disruptive behavior growing up, his father “put [him] away...he put [him] away [in a psychiatric facility] for a while when [he] was 13.” After that, he was placed in another institution up until the age of 18. Looking back over his childhood, he has few regrets. He noted that, “it was a learning process...It wasn’t nothing bad about it...I hated it at the time, but it did me some good.”

Many residents considered growing up “hard,” mainly because of the level of poverty in which they lived. Nathan noted that “outside of being poor” his childhood was good. Similarly, when asked why she considered growing up hard, Annette stated that it was difficult “trying to make it through life...when you don’t have enough money ...some people can have certain things and not have to worry about stuff and then some they got to worry cause you need certain things but then can’t get them.” Many spoke about similar struggles that their parents had providing basic necessities for them growing up. Despite such difficulties, many residents contended that their parents always found a

way to meet these needs. Theresa noted that, "...my mom did what ever she had to do to make sure we had not only the things we needed but also things we wanted...so, if she had to work two jobs or three jobs, she did whatever it took...."

*Table 2.* Number and content of responses about childhood experiences, n=20

Negative Childhood Experiences	Examples of Quotes	Positive Childhood Experiences	Examples of Quotes
<b>Neglect (6 respondents)</b>	"In all honesty, I can't think of anybody really positive...I relatively raised myself."	<b>Supportive Parents (10 respondents)</b>	"...my father. I really looked up to him, the way he uh, he worked and took care of the household and everything..."
<b>Drug Addiction (4 respondents)</b>	"...my grandmother practically raised me and when she died I was like 14...I was basically on my own cause my mother had a drug problem too."	<b>Fond memories (15 respondents)</b>	"I got a lot of fond memories of going out [to the country]...that was a nice time. That's when I was young coming up."
<b>Physical Abuse/Violence (5 respondents)</b>	"...[mom and dad] had a lot of problems, they used to fight. He used to beat on her..."	<b>Being with family (10 respondents)</b>	"family...just being around my family...just growing up, having fun, being a kid."
<b>Criminal Activity/Locked Up (4 respondents)</b>	"we used to go out and case homes and uh, we started burglarizing homes when we was real young."	<b>Having fun (4 respondents)</b>	"I had a real good childhood cause at the age of 10, I became interested in football and basketball and I played with the recreation team and I continuously played football and basketball through my adolescence"
<b>Discrimination (1 respondent)</b>	"I was told that the kids had a petition to get me out of the school because of my Cerebral Palsy and my seizures and sorts."		
<b>Poverty (5 respondents)</b>	"I was poor...outside of being poor, [my childhood] was good."		

Other residents explained how parental neglect and drug addiction took a toll on their early lives. When describing her childhood, Sarah noted that all she remembered was that, "[her] mother was always working, [her] father was always drunk and [she] was always with the baby sitter." According to Sarah, her mother left when she was seven years old. She stated that, "My mother even went to jail for not taking care of me....she left me when I was seven...she went to work and didn't come back. I just felt like she didn't love me." This resident, who now suffers from multiple personality disorder and manic depression, feels she was a victim of neglect growing up and describes her childhood as very "lonely." John also felt he had been neglected as a child, and that this has negatively impacted his current relationships with his family and with other people. When asked about positive influences in his life growing up, he mentions that, "In all honesty, I can't think of anybody really positive...I relatively raised myself." He noted that his negative childhood experiences have placed him at a disadvantage in his adult life

by failing to equip him with the social skills he needs to develop healthy relationships with people. See Table 2 above for examples of respondents' views regarding childhood experiences.

**Low functional status.** Throughout the interviews, respondents noted difficulties they had caring for themselves prior to the nursing home admittance. During the interviews, respondents were given a list of Activities of Daily Living (ADLs) and were asked if they needed assistance with them. Of the residents, six needed assistance with no daily activities. Of the remaining 14, respondents needed help with an average of 3.2 ADLs (median of 2). The mean was 2.2 for males and 5.1 for females. For African Americans, the mean was 2.3 and 5.8 for Caucasian Americans. The most commonly cited ADLs that respondents needed assistance with were walking (8), performing housework (7), and going up and down stairs (7). Also, six needed help with managing their money and preparing meals.

Through resident discussions, it was clear that low functional ability played a substantial role in the nursing home admission decision. Several residents mentioned they had difficulty with various activities such as walking, cooking, cleaning, and taking care of their appearance prior to the nursing home admittance. Carrie notes that one of the main reasons she is here is because she was told she needed 24/7 care. According to her, "I have been told that they want me here for 24/7 care. I've been told by rehab that they probably don't think that I have the ability to walk again." In addition to walking, she also needed help with 12 other ADLs such as managing her medications, using the toilet, and dressing. Similarly, other residents note how they were in need of substantial care prior to the nursing home admittance. Referring to the time when he entered the nursing home, Luke mentions that "I couldn't go to the bathroom by myself; I couldn't dress myself, couldn't get in and out of bed by myself, [and] couldn't shower." According to him, he is in a nursing home now primarily because his prior placement in a drug treatment facility had stairs which he had difficulty using due to his weakening legs. In addition to walking and going up and down stairs, he mentioned that he needed assistance with managing his medications, grocery shopping, and doing housework. The inability to perform housework, walk, manage medications, and prepare meals was evident in Lorie who suffered from AIDS, depression, and AIDS related dementia. When asked did she think this is where she should be based on her condition, she replies, "There's some things that I can do on my own, but I just can't cook or do washing and stuff like that." She notes that despite her difficulties, her physical condition has gotten much better since she has been in the nursing home.

Although low functioning was a major factor leading to nursing home admittance, a common theme emerging from resident responses is the belief that their functional status has improved since the admittance. When asked if his condition has improved, Luke states that, "I couldn't even stand up to go to the bathroom by myself, to pull my pants up and down at one time...but now I can do it myself...so I've come a long way." Nathan noted how his condition improved after the nursing home admittance. He stated that, "I was in bad shape when I first came here- when I first walked into the hospital. I was in a coma for about 24 days, they said I wasn't gonna walk ...and if I did walk, they said it would be about a year to 18 months. But, I did all that in about 30 days...." Several residents noted that they were currently able to do things that they could not do

when they entered the nursing home. Many felt the improvements stemmed from the care and the medications they had received while in the nursing home, and others attributed the improvements to their own self determination and will. Karen noted that, “I’m feeling much better and doing much better...eating three meals a day, don’t miss any doses of my medicines...I feel much better.”

Although many residents still had limitations in daily activities, most felt they did not belong in a nursing home based on their current condition. Some residents noted that they needed substantial care when they entered the nursing home but now can care for themselves. Mary, who had a stroke six years ago, noted that “I think I should be out in the community because I can do basically everything for myself except get dressed...and take a shower.” Similarly, Isaiah, who entered the nursing home primarily for wound care states that, “they took care of the wound—the wound been done for a while now. So, now I’m just waiting—now I’m just stuck here right now until I can get a chance to get out.” Others articulate that they do not think this is where they should be at this time because they are too young, or their condition has gotten significantly better and they no longer need care. Nathan states that, “I don’t think it is where I should be...Well, not where my condition is right now...but when I first got here, yeah.” Most feel they are stuck in the nursing home, not due to their functional status, but because of financial reasons, because they are homeless and unable to stay with family or friends, or due to their negative past histories such as time spent in prison.

**Support network.** When asked if residents had anyone they could go to if they had a problem or needed assistance with anything, 17 of the respondents could identify someone they considered a part of their support network. The majority of respondents (15) mentioned family members as being part of their support systems, while four mentioned friends, and two mentioned health care providers as people they would turn to if they had medical problems. Their level of contact with these individuals, by phone or in person, ranged from several times throughout the week to once every several months.

Although many residents could identify the name of an individual they could go to in time of need, it was still questionable how supportive these relationships truly were. Sarah, a heroin addict and former dancer, considered her “sugar daddy” her greatest support network because he would help her “get what [she] needed...get drugs...” He provided her with drugs and other material things as needed. According to her, “he stuck his neck out for [her] quite frequently.” She mentioned that he was the only person who had come to see her while she was in the nursing home, and he was currently looking for her an apartment to stay in after she left the facility. Similarly, Karen considered her mother and other relatives support mechanisms, even though many of her current problems stemmed from their earlier neglect. She noted early on that she was raised by her grandmother due to her mother’s drug addiction and that when her grandmother died she was left to raise herself. Although she claimed that her mother, aunts, and other relatives helped her when her grandmother died, when asked how she arrived at living on the streets as a child, she noted that:

...we lived at my grandmother’s house and then my aunt came in and put all of us out...so I was out on the streets living with different men.

This raises questions as to how supportive this network was when she needed help most as an adolescent. George mentioned the name of his sister and niece as someone he could go to when he needed help. However, further into the conversation, after being asked when he saw them last, he noted that he does not see them often, which raises many questions as to the true level of support stemming from this relationship.

Other residents appeared to have more stable support networks. Some spoke specifically about the kinds of support they had received in the past from these individuals. Mary mentioned her half sister, saying that, "She's taking very good care of me now...she's the one that does my laundry and buys the stuff that I need." Luke described how his family has offered instrumental support in the past, stating that, "My niece brought me a couple of pairs of pants, shirts...and my sister brought me some pants, shirts, socks and underwear." Other residents convey the intensity of the relationship by commenting on the level of contact they have with friends and family members. When describing the people she felt she could turn to when she needed help, Theresa mentioned her "in-laws that come at least every other weekend, and [her] brother Tom who tries to do the same thing." She further mentioned that even though she does not get to see her other brother as often, he calls on a regular basis. Some mentioned friends as their support networks in addition to family. Isaiah considered a friend he has had for many years, a part of his support network along with his sisters. When asked who he would turn to when in need, he noted that:

It would be one of them two people—my sister or my friend. We been friends for a long time...I would go to him, you know, if I had a problem I would tell him about it--him or either my sister.

Of those residents who had no one to go to when they had a problem or needed assistance, most had no contact with their family members. Annette had been in foster care for her entire life, and had no knowledge of her biological parents and had a distant relationship with her foster mother. In reference to monetary hardships she has had in the past, she noted that, "it ain't nobody that I can borrow from...I only have \$30 for the whole month so I can't spend it...so, ...when it come down to sickness, financial, health wise, relationship wise or what not...I just do the best that I can do..." Likewise, Jonathan conveyed that if he needed something, he would "...try and do without it...there's nobody I could go to."

## **Deductive Analysis**

**Effect of predisposing factors on nursing home admittance.** Many predisposing variables in the traditional domain of the behavioral model were evident in the lives of nursing home residents, placing them at risk for poorer health and care outcomes. Most of the residents were African American (15), male (13), and not married (17). Research suggests risk of nursing home admittance is higher among those who are not married, perhaps due to the lack of social support in their lives (Miller & Weinstein, 2002; Schoenman, 1995). Also, the results were consistent with research which shows that the working age nursing home population tends to consist of more minorities and males than the traditional nursing home population (Jones, 2002; Schoenman).

Many of the residents were also poorly educated, with only 11 of the respondents having a high school diploma or GED, consistent with other studies of this population (Miller & Weinstein, 2002). Many respondents noted how their not finishing high school had negatively impacted their lives in many ways. Involvement in criminal pursuits, early sexual activity, and drug abuse were often linked to low school participation, and were apparent throughout the responses of residents. Involvement in such activities often started at a young age and hindered them in many ways from finishing school because of consequences such as teen pregnancy, jail, or prison time. Isaiah, who was paralyzed due to a gunshot wound and also suffered from Depression, felt his current condition directly stemmed from his failure to finish school. He is currently having difficulty finding housing and employment due to his criminal background which started while he was skipping school. He has also had difficulty getting health care services for his legs because of his inability to access housing and transportation services due to his record. Consequently, he considers himself “stuck” in the nursing home even though he is capable of caring for himself in the community. In addition to the effects of the traditional predisposing factor, low education, on his current condition, his experiences also convey the effects of criminal behavior, a vulnerable predisposing factor, on health care use and outcomes.

Unemployment was also a traditional predisposing factor that remained problematic for many of the residents. Most of the residents had performed blue collar work in the years prior to the nursing home admittance, such as labor, construction, retail, and clerical work. Residents tended to have unstable work histories, and 14 were currently unemployed and dependent on SSI/SSDI for funds. Although it was not surprising that most residents were unemployed, many noted having difficulty throughout their lives finding and sustaining employment, particularly the types of positions they desired. Annette stated that, “I tried to work from age 20 up til now...but now it’s hard.” She also noted that she could never obtain the type of work she wanted, and was always stuck in “cooking jobs.” Similarly, others noted that they had no choice but to take construction and labor jobs because of their poor education and criminal histories. In resident responses, poor financial status resulting from sporadic employment was often associated with their current condition. Annette noted that she desired to leave the nursing home, but she does not have enough money to sustain herself once she leaves. She stated that, “I would’ve been done left if I could, but cause I ain’t got no money—I know it ain’t free living out there.”

Family structure was another traditional predisposing variable interacting in the lives of respondents. Because the overwhelming majority of respondents (12) were raised in one parent and often unstable household environments, these findings may suggest that such factors make an individual more susceptible to poorer health and care outcomes. Many of the respondents spoke of negative experiences resulting from their parents’ divorce or separation. Jeffrey, diagnosed with depression and anger problems, noted that much of the rebellion which sparked a string of experiences impacting his current condition, stemmed from his move from living with his mother to residing with his father at a very early age. This example also brings light to the effects of the vulnerable predisposing factor, mobility, on health care use and outcomes. Many residents in the sample spoke of being moved from one household to another while growing up. This was evidenced by several comments such as, “I was raised by my

mother and grandmother and was passed around to my aunt also.” John, who made this statement suffers from obsessive compulsive disorder and entered the nursing home following an attempted suicide. He contributes his current condition, particularly his poor relationship skills, to the instability he experienced as a child growing up. This instability could have predisposed him and other individuals in this population to poorer health experiences and outcomes.

The vulnerable predisposing variable, childhood characteristics, also played a substantial role in the health and care outcomes of residents. Several individuals spoke of how the instability in their childhood households negatively impacted their lives, and affected their current condition. Two female respondents, Karen and Sarah, noted that the problems arising from their home life, including neglect and drug abuse, contributed to their involvement in sexual activity at a young age. Karen, a 35-year-old woman with bipolar and schizoaffective disorder, felt she had no choice but to live with “men after men” in order to survive on the streets. In the process, she became pregnant for the first time at age 15. Similarly, Sarah, a 32-year-old woman diagnosed with depression, personality, and bipolar disorder, lost her virginity at 14, and got pregnant and married at 15; all in an effort to escape a household overflowing with drug abuse and neglect. Such examples convey the effects of childhood experiences on these residents’ current condition.

These two experiences further show the impact of the vulnerable domain variable, living conditions, on health and care outcomes. Both women lived on the streets from a very young age, living under unsanitary conditions and engaging in unsafe sexual behaviors. Sarah noted that prior to entering the nursing home, she was homeless--living in a “drug house” and engaging in prostitution for funds. Both females are currently addicted to heroin and are HIV positive.

Poor living conditions, particularly those arising from homelessness were common among many of the residents. A significant proportion of the sample (7) indicated that they were homeless prior to the nursing home admittance. Due to their homelessness, many mentioned having difficulties accessing health care, noted having drug and alcohol problems, poor personal health practices, and spoke of residing in extremely unsanitary living conditions. When asked if he received regular care before entering the nursing home, Jonathan noted, “I was homeless...I didn’t have no doctor or anything.” In his case, substance abuse, a factor often impacting the use of services among the homeless population, was also a factor affecting his worsened health state. Among his list of admitting diagnoses, alcoholic gastritis, dementia, and alcoholic hepatitis were cited in his medical records, indicating the existence of a significant alcohol addiction.

Similarly, when asked why she was in a nursing home at this point in her life, Annette spoke about her worsened health condition resulting from her homeless lifestyle. She stated that “they told me it was because of my diabetes and then me being homeless that...my diabetes has gotten more out of control...” In this conversation, she describes how being homeless and living under poor conditions has impacted her ability to control her illness as appropriately as she has in the past, consequently leading to her worsened overall health condition. She noted that in the past her condition was much more stable, but has recently become harder to manage. Factors such as inadequate care and unsanitary living conditions likely played a role in both Jonathan and Annette’s current

conditions. This is supported by prior studies which suggest that homeless individuals with mental illness often have difficulty accessing healthcare services regularly (Desai, 2003). Studies also convey the impact of factors such as drug abuse, low utilization of care, and engaging in unsafe practices as impacting health outcomes. Koegel, Sullivan, Burnam, Morton, and Wenzel (1999) showed that obtaining needed care is particularly difficult for this population because of problems with transportation, knowledge of funding mechanisms, and difficulty coordinating appointments. Because of such factors, many wait to use services until their conditions are at their worst state, and then utilize more expensive services such as emergency room care (Koegel et al.).

**Effect of enabling/impeding factors on nursing home admittance.** The absence of certain enabling resources was also a factor in respondents' use of health care services and their subsequent health outcomes. Respondents often spoke of problems arising from a lack of available social services such as transportation and housing. Carrie, suffering from cerebral palsy and depression, noted that "if transportation is a problem then care for me is a problem." She further explains that she is reliant upon transportation services in order to get to her health care appointments, and she has had difficulty getting care in the past due to transportation problems. Similarly, Isaiah noted difficulty he has had receiving the services he needs to improve the functioning in his legs. He noted that although there is a rehabilitation program at Johns Hopkins where he can get help strengthening and regaining the use of his legs, he cannot enter the program without adequate transportation and housing resources.

Other residents noted difficulty resulting from their lack of the enabling resource, income. Many spoke of difficulties they have had receiving SSI/SSDI funding either due to their condition (i.e., drug abuse) or their homelessness status. John, who suffers from both obsessive compulsive disorder and drug addiction, stated that, "I was on SSI for drugs, but they dropped that—that's no longer an excuse to get SSI so they said I could get it for depression." Annette noted how her being homeless hindered her receipt of SSI funds. She stated, "...the SSI people don't give you money if you don't have a house."

Competing needs, a vulnerable enabling factor, was of particular relevance to several respondents. Many spoke of a combination of factors such as drug abuse, physical ailments, and the need for basic necessities which were interacting in their lives at the time of nursing home admittance. Several respondents noted that they had stopped taking all of their medications prior to the nursing home admittance (e.g., mental and HIV/AIDS medications) because their only concern was "getting high." Subsequently, their mental and physical needs became less of a priority in comparison with their addiction. Sarah noted, "I have Hepatitis C and HIV...it might even be full blown AIDS...I quit taking my medications cause I was getting high...but I didn't care, I wanted to die."

Due to competing needs in this population, the lack of coordinated mental health care services was a major problem that arose from several respondent interviews. Several dual diagnosis (both mental and substance abuse disorder) respondents spoke of incidents where they were denied services at a mental health facility or clinic due to their drug addiction. John, who was receiving Methadone treatment and mental health services at an inner city treatment center, stated that "because I was on Methadone they were going to drop me—like that was the reason why I was depressed or I was having trouble with



mental illness.” He goes on to say that “there was a conflict of interest with their therapist...” He further noted that this denial of services led to his suicide attempt and subsequent nerve damage in his legs, which resulted in him being admitted to the nursing home.

**Effect of health care need on nursing home admittance.** Evaluated and perceived health care need were also significant factors which impacted residents’ use of health care services and their current condition. Many of the respondents indicated that they were receiving regular mental and physical health care services prior to the nursing home admittance. The majority of respondents (11) had seen a mental health professional at some point during their lives and/or could indicate where they went regularly to receive mental health services. Many mentioned clinics which treated both their physical and mental ailments. The role of evaluated need in health care use was evident because many of the respondents who had been diagnosed with HIV/AIDS and drug abuse problems were diagnosed with mental disorders while receiving treatment for these other conditions. Thus, while they were continuing to receive regular services and medications for their physical ailments, many residents were also able to access mental health services concurrently. John noted that he would go “...to the psychiatrist or the doctor at the methadone clinic.” Justin, who was diagnosed with schizophrenia, depression, and AIDS, noted that he saw a psychiatrist once a month at a community HIV/AIDS clinic that provided health care services for low income individuals in Baltimore’s inner city.

Although evaluated need compelled many residents to utilize health care services, perceived need also played a significant role in hindering many from receiving regular services. A common theme that emerged throughout respondent interviews was the belief that “there was never anything wrong with me—I’ve always been healthy,” so there was no need for a primary physician or any source of regular health care. Justin who was suffering from AIDS, schizophrenia and depression mentioned that prior to the nursing home admittance; he was hospitalized for pneumonia and kidney failure. He claimed that he did not know he was sick and noted that, “I’ve never been sick...never gotten a cold.” Other respondents acknowledged that they needed a primary doctor, but had not taken the time and effort needed to obtain one. Jeffrey noted that although he knew he needed a doctor, he would “...set up an appointment (with a doctor) and...never go.” Five residents indicated that if they got sick they would simply go to the emergency room for care. Jeffrey noted that:

I didn’t have a doctor—if I got sick, I would go right to the hospital...I’d go to the emergency room. And, uh, that’s nobody’s fault but mine....

Similarly, Annette maintained that:

The doctor told me at [the hospital], if anything does happen, to go to the emergency room...and that’s what I done....

To further show the impact of perceived need, those residents who were drug addicts spoke of the need to get high as being more of a priority than receiving regular health care. One resident noted that she "...was going to a place [to receive care], but quit going in May to get high...."

### **Discussion**

This study conveys the role vulnerability factors played in study participants' nursing home admittance. Both the deductive and inductive analyses produced responses evidencing vulnerability. The results informed one another and collectively provided a rich set of data using quantitative and qualitative techniques. The methods were used to depict participants' nursing home admittance through their own words, and to also apply a theoretical framework to help explain nursing home admittance among the sample.

Through the inductive analyses, it was evident which factors were most important to the respondents and how these experiences were conceptualized within the context of their lives. The deductive analyses provided a systematic assessment of the specific factors noted in the Behavioral model. Despite the differences in the techniques, it is shown through both analyses that childhood experiences of neglect, abuse (physical and drug), poor education, and criminal activity have placed this group at a disadvantage early in life. These negative experiences have affected their adult lives, leaving many respondents with poor social skills, drug addictions, inadequate employment opportunities, poor health, and few housing options. Such factors have made nursing home admittance a viable option at this point in their lives.

A major factor in respondents' current condition was their limited use of healthcare services. Although residents tended to know how to access health care services when necessary (i.e., emergency room), few noted having a primary care physician. Many of those with serious conditions such as HIV/AIDS did have a clinic doctor that they visited to receive regular medications and checkups. However, many of these residents also noted that prior to the nursing home admittance they had stopped obtaining these services. This cessation in service and medication use lead to worsened physical and mental conditions, making nursing home care a necessity. Consequently, short-term nursing home stays were a common occurrence due to the acute nature of participants' conditions at the time of admittance. This is evidenced by many respondents who noted that their functional status was poor at admittance and had improved tremendously by the time of the interview. Residents were often admitted into nursing homes primarily for rehabilitative care (such as wound care, diabetes care, antibiotic treatment, etc.) and once stabilized, were often able to return to the community if housing resources were available. This highlights an important shift in care offered by nursing homes--which have traditionally served as long term care facilities.

Because the results indicate that many individuals in this sample had problematic relationships, it is also possible that a lack of social support is operating in participants' lives to enhance their risk of nursing home admittance. Future research must further explore the impact of social support, particularly spousal and familial support, in nursing home admittance among individuals in this population.

Additionally, because lower levels of functional impairment were found among individuals who were African American and male, it is pertinent that future research

examines the unique factors increasing this populations' risk of nursing home admittance. Such results suggest that the circumstances surrounding the admittance of African Americans and males in this population into nursing homes may be more a function of a combination of socio-economic factors, chronic health conditions, and substance abuse, more so than the traditional risk factor, functional impairment. Such results also raise the bigger issue of competing needs in this population. Future research must assess the impact of competing needs such as drug addiction, housing, and chronic conditions on poorer health outcomes, inadequate use of services, and ultimately nursing home admittance among this group.

There are several limitations to this study. As stated previously, this study provides a mixed methods approach to understanding the reasons for nursing home admittance among a sample of residents. The various methods used are meant to inform one another and are not used as a basis for comparative analysis. A limitation inherent in conducting inductive and deductive analyses sequentially is the risk of one analysis biasing the other. However, conducting the inductive analysis prior to the deductive analysis allowed me to gain insight into participants' conceptualization of life events before taking into account factors in the Behavioral model. This provides a clearer and less biased understanding of participants' views of their current condition, outside the framework of the model.

Another limitation is that participants fail to explicitly link early life experiences (i.e., childhood, etc.) directly to their current nursing home admittance, but instead make more general comments about difficult life experiences and the manner in which those difficulties have shaped the course of their lives. Because this linkage is not explicit, it is not possible to definitively associate such experiences with the reasons for participants' nursing home admittance. However, it provides valuable insight into participants' perceptions of how their life experiences shaped their current condition. Additional research is needed to gain a clearer understanding of the relationship between early life experiences and current health outcomes such as nursing home admittance.

Another limitation of the study is the inability to fully take into account contextual or systemic issues experienced by the participants, such as, poor access to needed social services (i.e., SSI, SSDI, etc.), and a lack of job and housing opportunities. Although such factors were accounted for using the Behavioral model, it was difficult to ascertain the magnitude of the impact of such conditions on participants' lives, compared to personal life choices. Thus, there is the unfortunate risk of the reader blaming participants for their current state.

Finally, a weakness of the study is the small non-representative sample. Because of the size and make up of the sample, it is not possible to draw conclusions about the reasons for nursing home admittance among a working age population with mental illness. Instead, this study provides insight into the perceptions of a small sample of individuals regarding the factors associated with their nursing home admittance. Additional large scale studies are needed to make more substantial conclusions about nursing home admission based on the results from this exploratory analysis.

In conclusion, due to difficulties managing multiple physical and mental chronic conditions in conjunction with drug abuse, and difficulties accessing needed support services, this sample of working age nursing home residents is dealing with poorer health and care outcomes. Such results are particularly detrimental to residents as well as to the

healthcare system as a whole because greater costs are associated with institutionalizing this population rather than providing services for them in the community. In nursing homes and similar institutions, residents are often not receiving the array of services and supports that they need to live independently in the community. Consequently, individuals in this population are often leading non-productive and unfulfilled lives at costs to themselves as well as society.

This study provides much needed insight into the relationship between vulnerability factors and mental and physical health outcomes, and provides information that is essential for understanding how vulnerability impacts health care utilization. The information from this study can be used to inform researchers, policy makers, and clinicians about the characteristics of this population and their unique care needs, and can then be used to develop more effective strategies for providing needed care to this group while also reducing overall societal burden.

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