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Task Force Report

28

NURSING HOMES AND THE MENTALLY ILL ELDERLY

A Report of the Task Force on Nursing Homes
and the Mentally Ill Elderly
American Psychiatric Association

Soo Borson, M.D.
Benjamin Liptzin, M.D. (Chair)
James Nininger, M.D.
Peter V. Rabins, M.D.

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This is the twenty-eighth report in a monograph series authorized by the Board of Trustees of the American Psychiatric Association to give wider dissemination to the findings of the Association's many commissions, committees, and task forces that are called upon from time to time to evaluate the state of the art in a problem area of current concern to the profession, to related disciplines, and to the public.

Manifestly, the findings, opinions, and conclusions of the Task Force Reports do not necessarily represent the views of the officers, trustees, or all members of the Association. Each report, however, does represent the thoughtful judgment and consensus of the task force of experts who formulated it. These reports are considered a substantive contribution to the ongoing analysis and evaluation of problems, issues, and practices in a given area of concern.

Paul J. Fink, M.D.
President, APA 1988-1989

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PREFACE

Today, a greater number of individuals with psychiatric disorders reside in nursing homes than reside in psychiatric hospitals. Given that fact and the reality that, until recently, nursing homes .have received little attention in the general health care system, the Task Force on Nursing Homes and the Mentally Ill Elderly, a component of the American Psychiatric Association (APA) Council on Aging, was established by the APA Board of Trustees in December 1983. Its charge was to:

> "prepare a document that elaborates in detail the role of the psychiatrist in caring for patients in nursing homes who are suffering from mental illness, accomplished through:
>
> (1) a systematic search of the literature on the state-of-the art of psychiatric care approaches to nursing home residents with mental disorders;
>
> (2) a national search to identify expert psychiatric consultants to nursing homes, coupled with extensive consultation with such persons in defining research, service and policy issues. It would also include identifying, if possible, the forces that are operative in establishing good programs, as well as those obstacles to their development. Both stages of this research would entail particular attention to issues surrounding patients with Alzheimer's Disease."

The Task Force began its work in September 1984 with a search and review of the available literature. Additional information was gathered from sessions convened by the Task Force at 1984 and 1985 meetings of the Gerontological Society of America and the American Psychiatric Association. A number of psychiatrists responded to a notice placed in Psychiatric News, and provided information about their work and interest in issues related to nursing homes. The Task Force met with Dr. David Larson of the Biometry Branch, NIMH, to discuss the institutional sample contained in the Epidemiologic Catchment Area study. Finally, various organizations concerned with issues affecting the elderly, nursing homes, or mental health and illness were contacted for information. The most effective of these liaisons was with the American Association for Geriatric Psychiatry, in part because their membership includes many psychiatrists across the country who are willing to see or currently working with patients in nursing homes. This report presents the work and recommendations of the Task Force and is based on the experience of Task Force members, with input from psychiatrists from around the country. It reviews the published literature, summarizes the findings, and makes recommendations for future activities in the areas of research, training and policy. Over the last 5 years, nursing homes have received increasing attention. In October 1983, NIMH sponsored a 3 day conference on "Mental Illness in Nursing Homes." In 1986, the Institute of Medicine of the National Academy of Sciences published an influential report on

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"Improving the Quality of Care in Nursing Homes." That report was followed by changes in the federal conditions of participation regulations for long term care facilities in the Medicare and Medicaid programs and by major legislative changes affecting nursing homes as part of the 1987 Omnibus Budget Reconciliation Act, PL. 100-203. At the same time, Congress significantly expanded the benefit for outpatient psychiatric services under Medicare for the first time since passage of the original Medicare statute. With all these legislative and regulatory changes, it seems certain that psychiatric issues in nursing homes will receive increasing attention in the years to come. The last few years have seen a large increase in the number of papers in professional publications on psychiatric aspects of nursing homes. This Report includes papers published through December 1988. The Task Force hopes this Report can inform policy makers and practitioners and contribute to the ongoing development of psychiatric services for nursing home residents.

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I
THE SCOPE OF THE PROBLEM

Nursing homes now serve approximately 1.4 million residents, ten times as many as now reside in long term psychiatric hospitals. With the reduction in resident population of State and county mental hospitals, the growth of nursing homes and the high prevalence of mental disorders in nursing home residents, more individuals with psychiatric disorders are in nursing homes than are in psychiatric hospitals. Based on data from the 1977 National Nursing Home Survey, Goldman et al (l) estimated that 668,000 of the 1.3 million nursing home residents in 1977 had a diagnosis of a mental disorder. This chapter reviews earlier estimates and discusses some of the reasons why it has been difficult to estimate accurately the number of persons in nursing homes with DSM-III-R (2) psychiatric disorders or with behavioral problems.

The first study to look at the extent of psychiatric disorders and problems in nursing homes was done by the pioneering New York geriatric psychiatrist, Dr. Alvin Goldfarb (3). In 1962 he published a study of 506 persons in nine long-term care settings. He found that 87% of individuals in nursing homes, 80% of those in old age homes and 94% of those in State mental hospitals had a psychiatric disorder, usually "chronic brain syndrome." Behavior disorders were present in 22% of those in old age homes and 36% in nursing homes. Few patients were found to suffer from affective disorder in this study. Goldfarb concluded that there was a need for psychiatric services in old age and nursing homes since "four out of five of all aged persons in the non-hospital institutions surveyed were problems of management or were disturbing elements." Similar findings were reported more than a decade later by Teeter, et al (4). These authors reported that 85% of persons in a nursing home setting suffered from a diagnosable psychiatric condition. However, they also found that in two-thirds of the cases, no mention of a psychiatric diagnosis was made in the patient's record; there was no recognition that these individuals suffered from such a disorder. The authors recommended more psychiatric consultation to "ensure appropriate and effective care for psychiatric patients in such facilities."

Miller and Elliott (5) systematically reviewed medical records for 100 patients admitted consecutively to each of two nursing homes. Primary and secondary diagnoses were reviewed for accuracy and completeness. (Primary diagnosis refers to the condition mainly responsible for nursing home placement; secondary diagnoses are conditions requiring continued care). Diagnostic practices of 50 different physicians were represented. Sixty percent of patients admitted had a primary diagnosis of mental disorder. Two-thirds of these were due to brain disease; one in six of these was not noted. One-fifth of patients admitted were disabled by a chronic functional psychiatric disorder and one-third of these diagnoses were not noted. Over 80% of all errors in primary diagnoses resulted from a failure to identify correctly a disabling neurologic or psychiatric disease, or a combination of the two. Sixty-four percent of secondary diagnoses were incomplete or inaccurate. It was suggested that overall quality of care must be compromised by these errors. Almost 90% of secondary diagnoses were inaccurate for patients admitted from a psychiatric hospital. The authors concluded that, in 1976, physicians caring for the chronically ill elderly were poorly prepared to identify their patients' needs, particularly when patients suffered from behavioral problems in combination with medical diseases.

More recently, a large community study of the epidemiology of mental disorders was funded by the National Institute of Mental Health. This Epidemiologic Catchment Area (ECA) Study completed its data collection at five sites: New Haven, Connecticut; Baltimore, Maryland, rural Durham, North Carolina; a middle class area in Saint Louis; and an Hispanic area in Los Angeles. While several sites did oversamples of the elderly including institutionalized populations, only the Baltimore data on this group have been published to date. Using very restrictive criteria, German et al (6) found that 37% of persons in nursing homes in East Baltimore have a diagnosable mental disorder. However, a score of 17 or below on the Mini Mental State Exam was used to identify individuals suffering from a cognitive disorder, whereas a cutoff score of 24 was suggested when the test was initially published. Thus, the study missed many patients with milder dementias. Rates of depression were also quite low; this finding will be discussed later.

Barnes and Raskind (7) looked more specifically at the type of dementia found in nursing home residents. As the authors note:

> "Examinations were given to 64 elderly nursing home patients who met DSM-III criteria for dementia to determine if a specific diagnosis for their dementing disorder could be established through clinical evaluation. Pre-established diagnostic criteria were followed in diagnosing the cause of a patient's dementia. The diagnostic criteria for primary degenerative dementia, multi-infarct dementia, or alcoholic dementia were the same as those in the DSM-III. All but four of the patients evaluated could be given a specific, criteria-based diagnosis for the cause of their dementia. The two most common diagnoses were primary degenerative dementia (56%) and multi-infarct dementia (27%). Existing chart diagnoses for these 64 patients did not appear to be adequate as 39% had only a nonspecific diagnosis such as "organic brain syndrome," 30% had no diagnosis of any kind related to an organic mental disorder, and 8% had an inaccurate arteriosclerotic cerebrovascular diagnosis. These results suggest that demented nursing home patients have discrete clinical syndromes which can be assigned a specific diagnosis and that the current clinical diagnosis of these disorders can be greatly improved."

An issue rarely explored in the epidemiology of mental disorders is the prevalence of reversible dementia in nursing homes. In a 1982 commentary, Sabin and his collaborators (8) found potentially treatable medical illness in 25% of 136 nursing home residents with dementia. The authors suggested that some or many of these patients might have recovered their cognitive function if these medical disorders were treated. However the authors did not provide evidence that treatment, in fact, led to reversible changes. How many nursing home residents have dementias that would be reversed by treatment for underlying medical conditions is still an open question. Larson and Reifler (9) suggest, however, that such medical treatment is worthwhile in terms of overall patient well-being, even if the cognitive deficit does not improve. These authors prospectively studied the evaluation of dementia in 107 unselected outpatients; 83 had

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so-called "irreversible" dementias, including 74 who had an Alzheimer-type dementia. Fifteen patients had potentially reversible dementias, of which hypothyroidism and drug toxicity were the most common causes. Distinguishing features of reversible dementia were shorter duration, use of more prescription drugs, and less severe dementia. Almost half of the patients had other previously unrecognized treatable diseases. Most diagnoses were made from patient history and physical and mental status examination. Patients with reversible dementia improved but rarely reverted to normal. Objective improvement occurred in 25 patients after treating unrecognized coexistent medical and psychiatric diseases or stopping unnecessary medication. The authors suggest that careful clinical observation was the most useful part of the evaluation and that extensive testing may not be required for all patients. They caution that overemphasis on distinguishing reversible from irreversible forms of dementia may detract from the recognition of more common, treatable causes of dysfunction and suffering. This theme has been emphasized by an American Psychiatric Association Task Force on Alzheimer's Disease which stated "psychiatrists have unique skills that make them indispensable in the care and management of the more than 1.5 million patients (and their families) now suffering from the effects of Alzheimer's disease and other severe forms of dementia." (10)

Many questions also arise about the prevalence of diagnosable depression in nursing home residents. The ECA (6) data found that 7% of residents who lived in a nursing home for less than one year suffered from depression and that 2.6% of those individuals who had resided in the home more than one year had a depression. This confirmed the earlier report by Goldfarb (3) that clinical depression was relatively uncommon in nursing homes.

Clinical experience, however, suggests that major depression is difficult to diagnose in elderly individuals, especially those with dementia. Weiss et al (11) compared six depression rating scales against those dimensions of depressive symptomatology believed to be most prevalent in the very old. Most scales failed to include sufficient information on several items characteristic of "masked" depression in the elderly, such as a sense of failure in life accomplishments, helplessness, envy of others, hypercriticalness, hypochondriasis, and subjective cognitive deficit. In the opinion of the authors, these omissions limit the usefulness of most of the currently used scales in screening elderly populations for depression. They comment that relying on patient diagnostic interviews such as the Diagnostic Interview Schedule (DIS), used in the ECA project, underestimates the prevalence of depression. Many individuals may not meet the diagnostic criteria for affective disorder because they could neither comprehend the complicated questions nor express themselves in a way that would fulfill the diagnostic criteria. Higher rates of depression may be found when trained clinicians assess nursing home residents in a standardized manner and elicit depressive symptoms from demented individuals.

Merriam et al (12) tried to get around the problem by using a semistructured interview with family caregivers of community dwelling patients with carefully diagnosed Alzheimer's disease. They found that symptoms indicative of depression were "virtually ubiquitous" in this population, but that the diagnosis of a depressive syndrome was less common and more difficult to make.

Rovner et al (13) studied 50 residents randomly selected from among 180 residents of a proprietary intermediate-care nursing home. DSM-III diagnoses were made based on a semistructured clinical interview by a research psychiatrist and a research geriatrician. Ninety-four percent of the 50 had a psychiatric disorder, most often dementia. Eighteen percent had dementia with depression and another 8% had evidence for a major depression. In addition, the majority of demented patients also had non-cognitive symptoms, such as delusions or hallucinations, which led to an associated behavioral disorder. The authors suggest that confirmation of their results should lead to heightened recognition of the need for psychiatric services for nursing home residents.

In a more recent study, Chandler and Chandler (14) used a semistructured interview to assess a cross-sectional sample of all residents at a proprietary intermediate-care nursing home. Using DSM-III-R criteria, 94% of the sample had neuropsychiatric disorders. The most common psychiatric syndromes were dementia (72%), organic personality disorder (14%), and organic psychotic disorders (12%). Almost half of the patients had behavioral problems of agitation and aggression.

Specific diagnosis is as important in psychiatry as in general medical practice because it provides knowledge about prognosis and as Rovner and Rabins (15) point out, proper diagnosis suggests specific treatments. Unfortunately, no specific treatment is currently available for the underlying brain disease that causes Alzheimer's type dementia, the most common psychiatric disorder in nursing homes (7). Nevertheless and irrespective of diagnosis, it is important to identify specific behavioral and emotional problems in nursing home residents because these often require some management. Little epidemiologic data is available from this perspective. Zimmer et al (16) reviewed a random 33% sample of more than 3,000 charts of nursing home patients. A utilization review nurse examined the charts to determine the prevalence of specific problems. Sixty-six percent of patients had at least one significant behavioral problem. The most common problems were: verbal abuse, 12.6%; physical resistance to care, 11.4%; and physical aggressiveness, 8.3%. These behavior problems were more common in men than in women. Former mental hospital residents were not the patients identified here because only 4.7% of the patients had come from a psychiatric facility. While 58% of the patients were on a psychoactive drug, only 15% had received a psychiatric consultation. This study, while demonstrating the high prevalence of behavioral symptoms, relied on chart documentation which is often incomplete and unreliable. Furthermore, the chart review method is more likely to identify problems, such as violent behavior, that come to the attention of staff, and to underestimate problems such as isolation, withdrawal, poor appetite, and weight loss, which are easily missed or ignored.

The identification of specific behavioral and emotional problems in nursing home residents should be a major focus of future epidemiologic research, which can then serve as a basis for research on specific interventions in the nursing home setting. Rabins et al (17) reviewed previously published research in nursing homes and concluded that future research should make more use of reliable measures of cognition and abnormal mental experiences. They also recommended the development of additional reliable measures of behavioral disorder.

In summary, psychiatric disorders and emotional, behavioral, and cognitive problems are present in a majority of nursing home residents. Additional epidemiologic studies are needed in these settings to clarify the extent and type of problems. Even though many residents may suffer from a dementia due to an as yet untreatable brain disease, they often have physical, behavioral, and emotional problems, that may respond to appropriate psychiatric interventions. Attention to these issues will lead to improved resident well-being, and will help assure that nursing homes are positive treatment settings for elderly persons who need them.

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II
FORMER MENTAL HOSPITAL PATIENTS IN NURSING HOMES

Much of the attention paid to psychiatric problems in nursing homes over the past two decades has come as a result of concerns about deinstitutionalization. The closing of many state mental hospitals resulted in the transfer of some long term hospitalized individuals from state mental hospitals to nursing homes. This is sometimes referred to as "trans-institutionalization." The best estimate from the National Nursing Home Survey of 1973-4 is that 8% of nursing home residents are former mental hospital patients (1). Thus, the "deinstitutionalized" make up a small but significant minority of nursing home residents with psychiatric or behavioral disorder. Using data collected by Hollingshead and Redlich in 1950 and their own more recent data, Redlich and Kelllert (2) described trends in the mental health field over a 25-year period in New Haven, Connecticut. The dramatic decline form 3,000 to 1,000 resident patients at the state mental hospital was accompanied by substantial increases in mentally disturbed patients in nursing homes. In 1975, half of the aged chronically ill patients discharged from the state hospital were referred to nursing homes. Moreover, while most of the patients discharged in the 1960's were aged, by 1975 only 48% were over 65 and 20% were under 40 years of age. Moving patients to nursing homes appeared to have reduced the cost burden to the state mental health system significantly by shifting 50% of the cost of custodial care to the federal Medicaid program. Redlich and Kellert noted that while the nursing home had become one of the most important institutions for the care of the mentally disturbed, its financing and administration had moved the responsibility from the mental health to the welfare and general health care systems. Clearly, that shift has implications for the provision of psychiatric services in nursing homes.

There has been considerable debate about the policy of deinstitutionalization largely based on rhetoric rather than careful research. Carling (3), for example, argued that nursing homes have failed to meet the needs of former mental hospital patients particularly in the area of psychosocial rehabilitation services. In contrast, Shadish and Bootzin (4) assert that nursing homes are good alternative care facilities for former mental hospital patients and suggest ways to meet the patients' needs. Spiro (5) argues for reforming the state hospital rather than ignoring "150 years of experience in developing an effective institution to treat serious chronic mental illness." Becker and Schulberg (6) are critical of the policy of deinstitutionalization because of the states' failure to provide adequate community care services for former mental hospital patients. They argued that, in theory, the majority of elderly mental patients should do well in nursing homes, although backup support is not always available for ongoing management. In addition, an undetermined percentage of elderly patients remain too impaired for successful long-term care in nursing homes. These are often belligerent, explosive patients, wanderers, or patients whose problems are too many and too complex to be managed in a low-intensity care system. They point out that the number, profile, and clinical needs of these patients are unknown and that, if state mental hospitals are closed, no facilities will be available for their care.

Published research provides some information to illuminate this debate. Stotsky and his research associates (7) carried out a series of controlled and clinical studies from 1964-66, trying to answer a number of questions about long term hospitalized mental patients and nursing homes. They reached a number of conclusions. First, nursing homes had become a significant resource for aged mental patients. Over a four-year period, 699 patients from Boston State Hospital were placed in nursing homes. Of these, 383 had been hospitalized continuously for one year or more, and 150 of these for ten years or more. Second, 90% of nursing home administrators said they would accept incontinent, depressed, withdrawn, confused, disoriented, hypochondriacal patients, even those unable to feed or dress themselves. A majority of administrators found unacceptable patients who were suicidal, hostile, aggressive, assaultive, destructive, or boisterous, as well as those who wandered excessively, smoked in bed, or had severe alcohol or drug problems. Patients who were assaultive, threatening, destructive, noisy, negativistic, or wandering were feared by staff and they were returned to the mental hospital when their behavior outbursts were unmanageable. It was concluded that such patients should not be placed in nursing homes, unless these behaviors have subsided for more than six months. Third, the key factor in a successful nursing home placement was the absence of severe psychiatric disturbance. The mode of treatment, nursing home characteristics, casework activity, relationships with the family, attitudes of the staff toward the mentally ill, and other social variables were much less important. Fourth, patients placed in nursing homes did no worse than a matched group in the mental hospital over a six-month followup period. Fifth, the patients from Boston State were carefully screened and showed significantly less excitement, hostility, perceptual distortion, tension, motor retardation, thought disorder, impairment in social relationships, impairment in basic self-care activities, disorientation and nocturnal disturbance, compared with matched patients from the same hospital wards. Sixth, there was no reliable pattern of nursing home characteristics related to successful placement of mental patients. Seventh, there was no clear relationship between staff attitudes toward the mentally ill and successful placement. Eighth, there was significant overlap in behaviors of the mental patients with a matched group of patients placed from general hospitals or the community. Ninth, compared to patients placed from general hospitals, successfully placed mental patients were better prepared, more frequently liked the home and their roommates, had special friends, and were more active during the day. Tenth, nurses regarded mental patients as more disturbed than others and their behavior was characterized significantly more often as confused, disoriented, destructive, assaultive and withdrawn. These attitudes were somewhat at variance with actual behavior and reflected some negative bias toward the mentally ill and overgeneralization from the behavior of poorly adjusted

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patients. It was felt that these less favorable attitudes may at times have led to unfavorable dispositions.

This study should be replicated because many more patients, and perhaps more difficult ones, have been placed in nursing homes in the 20 years since this study was conducted. Furthermore, readmission to the State hospital is sometimes more difficult to accomplish today than it was in 1964 because there are fewer beds available and there is stricter pre-admission screening to prevent hospitalization.

Not all previously violent patients need remain indefinitely in a state hospital. In a study by Mueller and Iossi (8), 20 long-term psychiatric patients from the Iowa Security Medical Facility who had criminal charges against them were placed in open hospitals and aftercare settings. Fourteen had been confined for 20 or more years. Thirteen of the patients charged with murder or assault had been adjudged legally insane and were considered incompetent to stand trial. By 1969, a number of patients were no longer psychotic and the staff felt that continued confinement in a security hospital was no longer necessary, particularly because there had been no dangerous behavior for several years. The authors worked with the patients and educated the committing courts and parole boards. It took several years to accomplish the 20 placements. In follow-up of two and one-half to five years, eight were still residing in nursing homes, five were in custodial homes, and three were in open state hospitals. Two died of natural causes in aftercare settings two years after placement, one lived with his family, and one was serving a life sentence in prison for a later murder conviction. The authors concluded that the majority of older once-dangerous patients confined in closed psychiatric settings can be moved to more conventional facilities without fear of serious incident, assuming that their hospital behavior has become stable and nondestructive.

In a GAO-sponsored survey (9) of nursing home residents in New York and Texas, records were reviewed for 617 patients in a New York county multilevel facility and 240 patients in two proprietary homes in Buffalo; 140 records were reviewed in three nursing homes in Texas. The goal was not to identify all patients with mental disorders, but rather to ascertain the prevalence of those serious disorders that played a key role in the patient's institutionalization. Chronic psychiatric illnesses in former state hospital patients and chronic brain syndrome were the most frequent diagnostic groups affecting well over half of all residents. Availability of psychiatric services varied widely among the six homes. Minimally adequate coverage was available to former state hospital patients living in nursing homes; clearly inadequate or no service was available to the rest of the nursing home population. This survey highlighted the serious shortcomings in the implementation of federally supported deinstitutionalization. Despite a federal legislative mandate to provide necessary psychosocial intervention for publically funded Medicaid patients cared for in the public sector, services were lacking, narrow, or superficial in most instances.

A more recent controlled study by Linn et al (10) examined nursing homes as an alternative to psychiatric hospitalization. Four hundred three men, referred for nursing home placement from the psychiatric wards at eight Veterans Administration medical centers, were randomly assigned to: I) community nursing homes; 2) VA nursing care units (a nursing home with better qualified and more stable staffing, and a wider range of services than the proprietary nursing homes in the study); 3) continued care on the same ward; or 4) transfer to another psychiatric ward. Patients were included in the study if they met diagnostic criteria for schizophrenia or organic brain disease. Significant differences between settings were found in self care, behavioral deterioration, mental confusion, depression, and satisfaction with care. The results were strikingly consistent in showing that the group transferred to another ward was doing better and that the community nursing home group was doing worse. Medication use did not differ between the settings. In contrast to the outcome data, the cost data showed a significant advantage for the nursing home group. For those who completed 12 months in the study, the cost per patient ranged from $20,257 in the Community Nursing Home group, to $27,349 for the VA NCU group, and $29,479 for the group transferred to another ward at the VA Hospital. The results of this study confront policy makers with a difficult choice as to whether nursing homes are appropriate for placement, given the poorer outcomes but lower costs.

The empirical studies reviewed here leave many unanswered questions. Most patients, if carefully screened, can be "successfully" placed in nursing homes from psychiatric hospitals. There is no evidence, however, that this "community care" leads to better objective outcomes, though clearly some patients are more satisfied with their care in a nursing home than they were with that provided in a mental hospital. Concern has arisen that former mental hospital patients have been "dumped" into nursing homes that are unprepared for the problems they present. Families of physically ill nursing home patients sometimes complain about the abnormal behavior of former mental hospital patients. There are no data on whether some former mental hospital patients would do better in specialized "psychiatric nursing homes." Such facilities have been ruled out explicitly by the Medicaid law, which characterizes any facility as an "institution for mental diseases" if more than half its residents have a mental disorder (excluding dementia). Therefore, legislative change would be required to establish a new class of intermediate care facilities for the mentally ill. All of these above uncertainties leave open the question of what psychiatric services are helpful and necessary to former mental hospital patients residing in nursing homes. Patients with few behavioral problems may do well with minimal follow-up while seriously disturbed patients may not be manageable in a nursing home even with extensive follow-up. The next chapter describes programs set up to provide psychiatric services to nursing homes, often targeted specifically to former mental hospital patients.

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III
PROGRAM EXAMPLES

While nursing homes traditionally have not placed service or program emphasis on the provision of psychiatric services, this chapter describes a series of model programs developed explicitly to provide a comprehensive range of such services in the nursing home setting. The next chapter will discuss specific clinical services and the role of the psychiatrist in the

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nursing home. Most of the programs described in this chapter were developed in response to the concern that former mental hospital patients were being "dumped" into nursing homes without adequate follow-up. Such programs are not widely available, but this chapter reviews selected programs that have been described in publications.

Stotsky (1) developed a psychiatric intervention program for former state hospital mental patients placed in nursing homes and evaluated the effect of that intervention on patient management and adjustment to community placement. Sixteen nursing homes and a total of 141 patients were studied, including a control group that did not receive the intervention. The primary focus of the intervention provided assistance to nursing home staff; it did not provide direct patient care. Multiple outcome measures were used, including ratings of psychiatric symptoms and assessment of functional capacity in daily life. The study's results supported the value of psychiatric intervention for former mental hospital patients living in nursing homes. There were significant reductions in death and rehospitalization rates at six months, which persisted (but lessened) during the six months after intervention ceased. The effects on psychiatric symptoms were less impressive. Over time, patients were found to have more symptoms, physical illness, and functional disability in spite of the intervention. Despite this discouraging finding, nursing home staff were enthusiastic about the program; the intervention did improve the chance of patients remaining in the home.

Gurian and Scherl (2) described the collaboration of the geriatric unit at the Massachusetts Mental Health Center (an academic, state financed, comprehensive mental health center serving a defined catchment area of 200,000 persons) with the 50 licensed nursing homes with 2,342 beds in the catchment area. Some nursing homes refused to participate, while others collaborated enthusiastically. During fiscal year 1970, 207 visits were made to area nursing homes. Of 64 patients seen, only 13 required admission to the mental health center, although the home's attending physician had filled out a temporary commitment paper on half the group. Some patients did require transfer to another nursing home, but did not require admission to the state mental hospital for stabilization.

Khan (3) emphasized the importance of community outreach programs for former mental hospital patients. He described a geriatric team from Northampton State Hospital that placed elderly patients in suitable nursing homes and followed up with weekly visits to the homes. Such follow-up was mandated by new state licensing regulations for nursing homes that required discharged mental hospital patients to be followed for at least one year by psychiatric hospital staff. The likelihood of appropriate placement was increased by a further requirement that a hospital staff member visit the nursing home to evaluate the home's suitability before patient placement.

Dressler et al (4) described a psychiatric outreach program developed to resolve problems with weekly mental health clinic follow-up visits by nursing home residents who were former mental hospital patients. Patients had complained of being removed from their "home." It was felt an on-site program also could benefit other residents at the nursing home with psychiatric impairment. The nursing home staff conducted a preliminary screening of all 180 patients in the facility and identified 50 additional patients who might benefit from the psychiatric program. A psychiatrist from the mental health clinic then conducted small group interviews of the identified patients. This led to recommendations of medication changes and to approval of the 50 patients for group participation. The patients were largely middle-aged to elderly women without a living spouse. 50 percent were schizophrenic, 20% depressed or alcoholic, and the remainder had some organic impairment. More than 70% of the nursing home patients involved in this program at one time had been in a mental hospital. Three types of therapy groups were instituted: 1) a socialization group of patients with limited potential for change; 2) a higher level socialization group; 3) a group for patients who had the potential to leave the facility after working through underlying feelings of institutional dependency. The groups, each consisting of about 10 patients, met on a weekly basis for one hour under the direction of a psychiatric nurse and a member of the nursing home staff. Staff members then communicated pertinent information to the director of the nursing home, who, in turn, recommended changes in nursing care plans: The cost of the clinic's staff time was charged to the patient, who, in the majority of cases, was covered by private insurance, Medicaid, or Medicare. The program was expanded to five additional nursing homes; 175 patients were seen on a weekly basis. The authors reported a reduction in patient management problems, more effective nursing care plans written in the charts, and improved staff attitude. The Stockton Geriatric Rating Scale, which assesses day to day behavior in an institutional setting, and the Brief Psychiatric Rating Scale became routinely used at the nursing homes. The outreach program provided stimulation to patients and staff alike, and demonstrated that with proper diagnosis and treatment, many patients can have brighter prospects for rehabilitation than was believed previously.

Another consultation program to nursing homes also developed in response to the deinstitutionalization of patients from a large state hospital that closed in 1975 was described by Jellinek and Tennstedt (5). The nursing home services team included a psychiatrist, two nurses, a social worker, a psychologist and an occupational therapist. The team provided service to twenty-five nursing homes in a catchment area of approximately 150,000 people in north central Massachusetts. Several types of consultation were provided. Client-centered and consultee-centered consultation dealt primarily with problems of depression and disorientation and the accompanying behavior disorders of agitation and assaultive behavior. Program-centered administrative consultation helped the facility deal with issues such as high staff turnover, staffing patterns, and staff conflicts. Finally, staff development programs provided information at staff request on topics such as organic brain syndrome, assessment of suicidal intent, psychoactive medication, and behavioral management of elderly patients. The authors found that brief psychotherapy was effective in patients with mild depressive reactions, paranoid reactions, and situational disturbances. Specific treatment of nursing home residents and consultation to nursing home administration and staff fostered an environment more responsive to the needs of the residents.

Another project conducted by the psychiatric staff of a large psychiatric institution to help with the transition and relocation difficulties experienced by deinstitutionalized patients entering a nursing home was described by White (6). As nursing home beds in the community became available, patients were screened by staffs of both facilities to determine if they met nursing home admission criteria. A consultation team, consisting of a psychiatrist and two nursing educators provided client-centered case consultation and program-centered administrative consultation to the involved nursing homes. Each group of nursing home staff met on a weekly basis with the psychiatric team for six weeks. Each meeting lasted for one and one-half hours. The effectiveness of the consulting team's approach was evaluated by written staff summaries. It was found that as a result of the consulting team's efforts, fewer patients were reported for acting out behavior and a more positive staff attitude was evidenced at screening meetings. The author recommended monthly rounds at nursing homes by an interdisciplinary psychiatric team and suggested that more input from nursing assistants -- the direct care providers of patients -- be obtained to identify both patient and staff needs.

To define more clearly the role of the mental health consultant in the nursing home, Pavkov and Walsh (7) described a charting tool, the Mental Health Profile (MHP). The authors were members of a geriatric evaluation and treatment team, that provided frequent consultation at the request of nursing homes in their catchment area. The MHP was developed to convey, in a concise manner, the ongoing mental status of a nursing home resident. The Mental Health Profile chart provides a checklist across a number of mental status variables, and has potential for use in sixteen separate evaluations. The form enables a reader to quickly identify changes in the clients' mental status. A separate form provides a narrative description of each disturbance. A detailed treatment plan is also included in each patient chart. The forms are an adjunct to, and not a replacement for verbal communication. Through use of these forms, the authors felt that

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role confusion of nursing home staff members and mental health staff members was significantly reduced and client care was efficiently coordinated.

In most of the programs described above, the psychiatric consultation was provided by salaried state employees or by staff hired through grants or contracts from State or federal agencies. In particular, federally funded Community Mental Health Centers (CMHCs) were required by statute to provide consultations to nursing homes in their area. When this direct federal grant program was replaced by a block grant to states, some of these nursing home consultation programs were funded through state funds; others were terminated because of a lack of funds. Some programs were able to continue to provide consultation to all nursing home residents in their service area while others restricted services to former state mental hospital patients, notwithstanding the fact that most other residents with psychiatric problems were similarly publically funded through Medicaid and Medicare.

A different approach to the treatment of psychiatric problems of nursing home residents has been the development of specialized nursing home treatment units. An example of this is a 44 bed mental health unit set up on one skilled nursing floor at St. John's Home for the Aging in Rochester, New York (8). The unit opened in October 1972 and, by January 1974, had admitted 103 patients. Two-thirds of the patients were cognitively impaired, while one-third had depression, paraphrenia or personality disorders and could be expected to improve with psychotherapeutic techniques. Patients were admitted from other levels of care at St. John's, from hospitals (psychiatric or medical), or from the community (own home or nursing home). One-third of the patients were discharged to home or to a lower level of care. Individualized treatment was provided by an interdisciplinary team consisting of physician, social workers, nursing staff and activity therapist. Treatment modalities included a therapeutic milieu, reality orientation, remotivation therapy, occupational therapy, physiotherapy, drug therapy, electroshock therapy, and behavior modification. One practical problem faced by the program was that Medicare Skilled Nursing Facility (SNF) benefits were only payable if a patient had been hospitalized previously for at least 3 days. In addition, some patients remained on the unit because of a lack of Medicaid ICF beds.

Some patients could have been discharged home if outpatient care were available in the community. This program has continued to evolve and is now an integral part of an active academic program in geriatric psychiatry at the University of Rochester School of Medicine.

Another "psychiatric nursing home" unit (9) was developed by a proprietary intermediate care facility in Boston in collaboration with the academic program in geriatric psychiatry described earlier (2). The goal was the care of elderly patients unable to be managed in a conventional nursing home, but not in need of acute or long-term psychiatric hospitalization. It was expected that some difficult patients would stay on the unit indefinitely while others would respond to proper diagnosis and treatment and be discharged to conventional nursing homes or other residential settings. The program was designed as a model of public and private collaboration for the care of the elderly mentally ill. Many changes were needed to transform the nursing home into a therapeutic community. For example: the nursing station was made more open and accessible to patients; meals were served in a central dining area rather than in patient rooms to enhance socialization; a small backyard area was enclosed and patients were able to plant and maintain a garden; two large rooms were converted to activity and group meeting rooms with food and drink dispensing machines just outside; and finally, photographs of each resident were placed on their room doors and inside their medical record. The usual nursing home staff were supplemented through a state contract that supported a special psychosocial staff (including a program director, a director of in-service training, a head psychiatric nurse, a psychiatric social worker, an occupational therapist, a psychiatrist, a behavioral psychologist and several case managers). Medical care was provided by a geriatric internist and geriatric nurse practitioners. Each potential admission was screened carefully, and after admission, a multidisciplinary care plan was developed. The program focussed on decreasing antisocial behaviors and increasing ADL skills. Each patient was seen at regular intervals by the geriatric psychiatrist and participated in groups such as reminiscence, nutrition, art, reading, conversation, recreation, movement, writing, sewing, women's issues, bible study, singing and dance. Of the first 115 patients admitted from December 1982 to April 1985, 37% came from Department of Mental Health (DMH) facilities while the other 63% came from other hospitals, from nursing homes or from home. The patients from DMH facilities were somewhat younger, more likely to be male, less likely to have ever married, much more likely to have a thought disorder, and were less likely to be discharged to a conventional nursing home. Overall, 31% of the program patients stayed at the study home; 32% were placed in more intensive settings such as community mental health center inpatient units, state psychiatric, private psychiatric or chronic care hospitals. Thirty-three percent were placed in less intensive conventional nursing homes and 4% died while at the study home. Of the 42 patients admitted from DMH facilities, only 33% returned to those facilities. By providing an appropriate lower level of care for those patients not returned to DMH facilities, the program demonstrated some cost savings. All patients benefitted from the diagnostic, assessment and placement services that channeled patients to settings where they would receive the appropriate level of care. Despite the demonstrated benefits of this program, a variety of problems led to the program's discontinuation (10). Given the large number of disturbed elderly patients who could be managed in a less intensive setting than a state mental hospital, it is likely that other "psychiatric nursing homes" will be developed as demonstration projects awaiting the creation of a new class of Intermediate Care Facilities for the Mentally Ill analogous to ICFs for the Mentally Retarded.

Some attention has also been given to the establishment of specialized units devoted exclusively to patients with Alzheimer's type dementia (11, 12). Rabins (11) suggests that such units can: (a) be staffed by persons specially trained to care for cognitively impaired patients resulting in higher quality care; (b) be designed to be physically safer and to facilitate reality orientation; (c) diminish treatable behavioral problems; (d) concentrate the resources needed to care for these patients; (e) offer families the reassurance of specially designed surroundings and expert staff; and (f) spare other nursing home residents the stress of living with severely cognitively impaired patients with behavioral problems. Such units can also become valuable research and training resources for health care professionals. Such units, however, do pose potential disadvantages. It may be difficult to attract and retain staff for a unit with such severely disturbed patients. Families may resist having their relative placed on such a unit for fear it will precipitate a rapid decline particularly since there will be limited opportunity to interact with cognitively intact residents. Admission criteria for such units will have to be developed. Such units may have lower expectations for patients and may be less likely to look for treatable problems. Finally, such units will be more expensive than usual nursing home care.

Ohta and Ohta (12) identified the critical variables characterizing special Alzheimer's units including philosophy, environmental design, and therapeutic approach. Philosophic differences include the definition of what makes a unit "special" for SDAT patients; are SDAT patients or other nursing home residents the primary beneficiaries; and is the focus on custodial or growth-promoting care? Programs differ in environmental characteristics such as size of the unit, type of room, architectural design, and space for wandering. Therapeutic approaches vary in terms of staff-to-patient ratios, consistency of staffing, staff training, patient admission and discharge criteria, and orientation from custodial care to promotion of independent functioning. The authors suggest that given the heterogeneity of these special units, careful evaluation needs to be done to assess which program characteristics benefit which patients.

The last "model" for providing psychiatric services in nursing homes is that of a private psychiatrist who develops a relationship with a particular nursing home. Depending on the size of the nursing home, the psychiatric

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consultant may visit from weekly to monthly. When individual patients are seen, the services can be billed directly to them or to their insurance carrier. Generally, there will be sufficient new referrals and follow-up evaluations to fill a block of several hours. The fees for such direct clinical work usually are comparable to those for office psychiatric visits, though the additional expense and time for travel need to be considered. A formal arrangement including a monthly retainer from the nursing home is clearly preferable and allows the psychiatrist to consult with nursing home staff or provide valuable in-service education programs. While many private psychiatrists do enjoy seeing patients in nursing homes, there are few published descriptions of their work. Tourigny-Rivard (13) described her work with a 50 bed nursing home in a small farming town in Ontario, Canada. She visited monthly and evaluated new referrals, followed up several patients and presented In-Service programs on topics such as depression, death and dying, behavior therapy and use of psychotropic medications. Over a period of 18 months, 21 residents were evaluated for reasons such as "aggressive/uncooperative/agitated behavior" or "depressed appearance." Not surprisingly, the initial referrals tended to be aggressive/uncooperative patients while later referrals were more likely to be depressed. For most patients, the house physician had previously attempted treatment with psychotropic medication. Written comments provided by the nursing staff, nursing home physician and nursing home administrators suggested that not only did specific patients improve but also there were improvements in staff attitudes towards psychiatric care, interdisciplinary team relationships, staff confidence in their ability to handle emotionally disturbed residents, early detection of depression, and staff initiated therapeutic programs for residents. Clearly, regular psychiatric consultation in the nursing home was found to be very useful.

In summary, several different examples of programs providing psychiatric services to nursing home residents exist. All of them have been shown to be feasible and effective in different locations. Any individual nursing home that desires psychiatric consultation should consider which model is likely to work best at the facility, given the resources in its particular community. Careful evaluation of the cost-effectiveness of various programs can help determine which programs are best suited for which circumstances. Increasingly, private psychiatrists will see the nursing home as a professionally challenging and rewarding setting with urgent and generally unmet clinical needs. Depending on how new regulations requiring pre-admission screening and annual nursing home resident reviews (P.L. 100-203) are crafted and implemented, the demand for psychiatric services in this setting may be either considerably enhanced or diminished. Time and promulgation of the regulations will be the final arbiters. A recent book by Smyer et al (14) discusses, in detail, many of the issues involved in mental health consultation in nursing homes. However, that book does not discuss the specific contributions of a psychiatrist consultant in nursing homes. The next chapter discusses both the role of the psychiatrist and the use of specific treatment modalities in greater detail.

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IV
THE ROLE OF THE PSYCHIATRIST AND SPECIFIC PSYCHIATRIC INTERVENTIONS IN NURSING HOMES

In the last chapter, examples were given of programs to provide psychiatric services in nursing homes. This chapter focuses on the specific role of the psychiatrist in the nursing home setting. The psychiatrist is a physician with special expertise and training in the assessment and differential diagnosis of emotional, behavioral and cognitive problems associated with normal aging and with physical and mental disorders. Furthermore, the psychiatrist can prescribe and provide pharmacologic and psychosocial interventions to help in the management of nursing home residents with problems. The psychiatrist can serve as a consultant to nursing home staff in the design and operation of therapeutic programs and environments. Finally, the psychiatrist can provide in-service training and education to assist nursing home staff improve their ability to assess and manage patients. Each of these roles will be addressed in this chapter
.

ASSESSMENT AND DIFFERENTIAL DIAGNOSIS

Careful assessment is a necessary precondition of psychiatric intervention with a nursing home resident. Often the resident presents a complicated picture of a cognitive impairment, a number of physical problems being treated with various medications, and behavioral symptoms which may be related to the above or to a primary psychiatric disorder. Although some patients or their relatives may request a psychiatric evaluation, more often the direct care staff make the observation of behavior that lead to such a request. Initially the psychiatrist may be consulted only for gross disturbances such as agitation, assaultiveness, suicidal behavior or wandering. Over time, however, the psychiatrist can help the staff identify more subtle behaviors such as withdrawal, decreased participation, poor appetite, crying or quiet confusion which are easy to ignore or miss. These less obvious symptoms may be warning signs of more serious psychiatric problems; early intervention is often helpful.

Assessment of the geriatric patient has been described fully elsewhere (1); only a brief discussion will be given here. A careful description of the presenting problem is essential. Specific behaviors, such as crying or accusing others of stealing things should be described. Global judgments such as "depression" or "paranoia" should be avoided. Did the problem develop suddenly or gradually? Has it been present since admission to the nursing home or only recently? Is there a previous history of similar problems before or after admission? If so, what treatments were provided previously? Is there a family history of similar problems? Too often, nursing homes do not request or receive information on prior psychiatric treatment. Since physical problems or the medications used to treat them can cause psychiatric problems, it is important to have complete information on the patient's medical history and current medication. The

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results of a complete physical exam and appropriate laboratory studies should be obtained.

The foregoing information can help uncover the cause of symptoms essential before treatment is started. Quite often, nursing home staff request a pharmacologic intervention to treat symptoms when the underlying cause may have a more specific intervention. For example, an 84 year old nursing home resident was referred for admission to a psychiatric hospital for treatment of "severe agitation," thought to be due to his underlying dementia. On his admission physical examination, he was noted to have a fecal impaction. Disimpaction led to resolution of his agitation, and proper attention to his bowel function prevented future recurrences. In another case, an 86 year old woman was referred for evaluation of "paranoia" since she had barricaded herself in her room and refused to tolerate a roommate. Careful history revealed that she had been started on 60 milligrams of the steroid drug Prednisone for an unusual hematologic problem. Her primary care physician agreed to stop the drug and her "paranoia " disappeared. In some cases, psychotropic medication is the cause, not the solution to the presenting problem. For example, an 85 year old man was referred for "severe agitation" which had worsened acutely. Careful history revealed that, because of mild agitation, his dose of thioridazine had been increased. It was after this increase that he became more confused and more agitated. In addition, he developed urinary retention which required acute intervention. In this case, he did better off the psychotropic medication than on it.

An efficient way to gather the information needed is to have the nursing home staff fill out a pre-consultation form (2). This approach also encourages the staff to consider carefully the nature of the resident's problem, its cause, potential interventions, and the role and function the consultant is expected to perform.

A careful assessment may lead to a variety of recommendations. Sometimes, the existing treatment approach is adequate and nothing new is required. Sometimes, suggestions may be made for medical workup or treatment. Most often, the psychiatrist will suggest one of the psychiatric interventions discussed in the next section.

MANAGEMENT

All currently accepted modalities of psychiatric treatment have a place in the treatment of nursing home residents with psychiatric disorders. Pharmacologic, behavioral and psychotherapeutic approaches are discussed separately.

Pharmacologic Interventions

The use of any psychotropic drug in an elderly patient presents special problems and special expertise is required to prescribe appropriately. Elderly patients are extremely sensitive to the side effects of these drugs. There are many reasons for this including increasing sensitivity of nerve cell receptors, decreased activity of cholinergic and dopaminergic neurotransmitter systems, decreased metabolism of drugs by the liver, and slowed excretion of drugs by the kidney. The field of clinical geriatric psychopharmacology is developing rapidly and has been summarized by Salzman (3). Of all geriatric patients, nursing home residents are the most challenging because they tend to be older, more frail, and have multiple medical problems for which they take multiple medications which can interact with psychotropic drugs. Given the risks of psychotropic drug use in this population, the potential benefits need to be clear in order to justify their use. Unfortunately, few nursing homes regularly consult with psychiatrists about the appropriateness of psychotropic drug use for nursing home patients. Moreover, there are few published studies of drug treatment in this population; relevant studies are reviewed here.

Concerns have often been raised that psychotropic drugs are over-prescribed or misused by non-psychiatrist physicians treating patients in nursing homes. For example, Schmidt et al (4) reviewed the records of 1155 Medicaid patients in Utah nursing homes with ICDA psychiatric diagnoses and found that, over time, most patients received increased medication and became less active. They speculated that psychotropic medication was being used to achieve a more docile and compliant clientele, and that low activity levels were encouraged to maintain order in the nursing home. The authors believe that nursing homes have become "back wards" in the community, where patients receive little therapeutic intervention and, hence, deteriorate.

In another study (5), Ray et al reviewed 384,326 prescriptions for 5,902 Medicaid patients residing continuously for one year in 173 Tennessee nursing homes. Of these patients 43 per cent received antipsychotic drugs; I9% were chronic recipients (received at least 365 daily doses per year). Of the 1,580 physicians who cared for these patients, 42% prescribed antipsychotic medication. Physicians with large nursing home practices (10 or more patients) prescribed 81% of the total antipsychotic medication and were usually family practitioners (78%) and in rural practice (47%). As nursing home practice size increased, doctors prescribed more drug per patient. Wide variation in antipsychotic drug use occurred among nursing home residents; the chronic recipient rate ranged from .0 to 46 per cent. More drug was given per patient in larger homes. Typically, one physician provided care for the majority of a nursing home's patients. The proportion of a home's patients seen by this dominant physician was correlated with the chronic recipient rate. The authors concluded, "These findings provide epidemiologic evidence suggesting misuse of antipsychotic drugs in nursing homes. They illustrate the need for investigations of techniques for patient management in nursing homes which rely less upon psychotropic drugs." However, a serious drawback to this study was the absence of clinical information on the patients, such as diagnosis or drug use prior to nursing home placement. It was not known whether the drugs were prescribed as part of an overall treatment plan and monitored for their effectiveness or side effects. Conclusions about appropriateness can only be made by examining individual patients.

Another study raised further concern about the appropriateness of drug prescribing in nursing homes by focussing on polypharmacy (6). Medicaid pharmacy claims were reviewed for 5,902 continuous nursing home residents and a comparable group of ambulatory patients. During the study year nearly 60% of the nursing home residents and 23% of the ambulatory patients were prescribed drugs with anticholinergic effects. Based on recommended doses of the drugs, 565 of the nursing home patients and 413 of the ambulatory patients could have received three or more anticholinergic medications concurrently. Although specific neuroleptic and tricyclic antidepressant drugs differ in their anticholinergic activity, nursing home physicians did not seem to choose drugs selectively within the two classes to minimize the potential of anticholinergic toxicity. This study suggests that the risk of anticholinergic toxicity may be underestimated by nursing home physicians and that a careful review by an expert in psychopharmacology is desirable.

Recently, Beers et al (7) reported their findings on medication use among 850 residents of 12 representative intermediate care facilities in Massachusetts. Data were collected on medications prescribed and actually used during a one 'month period. They found that more than half of all residents were receiving a psychoactive medication and that 26% were receiving antipsychotic medication. Twenty-eight per cent of residents received sedative/hypnotic medication, primarily on a scheduled rather than an as-needed basis. Many of these residents (26%) received diphenhydramine as a hypnotic, even though it is strongly anticholinergic. Of those patients receiving benzodiazepines, 30% were on long-acting drugs which can build up over time in older patients. The most commonly used antidepressant was amitriptyline, not only very sedating but also likely to cause anticholinergic side effects. The authors concluded: "These data indicate that despite growing evidence of the risks of psychoactive drug use in elderly patients, the nursing home population studied was exposed to high levels of sedative/hypnotic and antipsychotic drug use. Suboptimal choice of medication within a given class was common, and use of standing vs as-needed orders was often not in keeping with current concepts in geriatric psychopharmacology. Additional research is needed

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to assess the impact of such drug therapy on cognitive and physical functioning, as well as to determine how best to improve patterns of medication use in this vulnerable population." In an accompanying editorial, Riesenberg (8) echoed the authors' concerns about psychoactive drug prescribing in intermediate care facilities. He cautioned, however, that this study did not analyze the specific indications for any of the medications prescribed and, thus, could not determine to what degree the medication was warranted. Despite the caution, Riesenberg argues that more careful use of psychotropic drugs in institutionalized elderly patients could avoid unwanted consequences of oversedation, orthostatic hypotension, and decreased cholinergic tone including mental deterioration, bowel and bladder dysfunction, and falls leading to hip fractures.

It is essential that psychotropic drug prescription be thought out carefully as part of a comprehensive care plan. The role of the psychiatrist as a consultant to other physicians engaged in nursing home practice becomes critical. The drugs are potent agents with many serious side effects. However, it is equally inappropriate to refrain from using medications in patients who could benefit from them if carefully prescribed (9). Psychotropic drugs can be very useful in the treatment of psychiatric disorders such as depression or mania and/or symptoms such as delusions or hallucinations. For example, several classes of safe and effective antidepressants are available to treat the symptoms of serious depression (1). The recognition of serious depression in nursing home residents is often complicated by the presence of moderate or severe dementia. Even moderately demented patients can respond to antidepressant treatment. An 82 year old severely demented woman was quite agitated and restless. Antidepressant treatment was considered because she would occasionally walk by the nursing station, hold her head in her hands, and say "I feel so miserable." When asked what was bothering her, she was unable to describe her feelings or to remember what she had said. However, on nortriptyline (10 mg bid) she was much less agitated, could sit calmly in a chair and showed no more dysphoria.

Some patients with depression have a bipolar disorder with bouts of depression and hypomanic or more severe manic periods of elation, hyperactivity, grandiosity and impulsiveness which can lead to excessive spending or sexual indiscretion. In elderly patients, these "high" periods may be difficult to diagnose because they may be characterized more by irritability, confusion or paranoia than by the typical symptoms described above. Various medications have been used to treat or prevent these "highs," but the mainstay of treatment is the salt lithium carbonate (1). In a study of very elderly nursing home patients, Bushey et al (10) showed that used cautiously and monitored carefully, lithium could be quite effective in bipolar patients. A case example illustrates the effectiveness as well as the risks of lithium in such patients. A 78 year old man with a long history of bipolar disorder and frequent episodes of mania as well as depression became unsteady on his feet when his lithium level became too high. He suffered a fall which left him comatose for days, and he was taken off lithium. After he woke up and stabilized, he was transferred to a nursing home where he seemed slowed down, disinterested and depressed. One morning he woke up singing loudly and made crude sexual remarks to staff and other residents. He was placed back on lithium and became more calm and more appropriate. Since he was also no longer depressed he was motivated to return home to his wife, where he remained for the last 7 years of his life.

The treatment of serious affective illness may require the use of electroconvulsive therapy (ECT), a safe and effective procedure with tolerable side effects when done appropriately (1). Nursing home residents who may benefit from ECT are usually treated in a hospital setting. In cases of severe or suicidal depression, ECT can be life saving. In other cases, ECT can be effective when antidepressants are ineffective or not tolerated. For example, an 87 year old woman was admitted to a nursing home after falling at home and being hospitalized for a bruised hip. She became agitated and constantly called out for help. When someone sat and talked with her she would calm down, but as soon as she was left alone, she would start calling out again. Although there was no question that she was moderately demented, she was able to tell staff tearfully that she missed being home with her dog. Following an unsuccessful trial of antidepressants, she was given a short course of ECT and her spirits improved greatly; she stopped calling out, and was able to enjoy her family's visits at a nursing home near them.

As noted above, much of the concern about the use of psychotropic drugs in nursing home residents relates to the treatment of agitated demented patients. There are few studies comparing various pharmacologic approaches to the treatment of such patients (11). One controlled study by Barnes et al (12) compared the therapeutic efficacy of thioridazine, loxapine, and a placebo in the treatment of behavioral disturbances in nursing home patients with dementia. Each subject had at least three behavioral symptoms, including irritability, hostility, agitation, anxiety, depressed mood, sleep disturbance, delusions, or hallucinations. Neuroleptic medications seemed to be effective for the specific behavioral problems of anxiety, excitement, emotional lability, and uncooperativeness. A few subjects appeared to benefit greatly from active treatment, but the majority of patients maintained on active medication were not rated markedly or even moderately improved at the end of the study. As in earlier studies of neuroleptic medication in institutionalized dementia patients, there was a prominent placebo effect. Sedation, extrapyramidal symptoms, and orthostatic hypotension were common side effects among patients treated with the active drugs, which may have limited their effectiveness. The authors also emphasized the importance of identifying possible social and environmental solutions for behavioral disturbances to avoid the use of medication, if possible.

A psychiatric consultant can weigh carefully the risks and benefits of pharmacologic treatment, can consider other alternatives such as described elsewhere in this chapter, and, if a medication trial seems warranted, can minimize the risks and can monitor the patient for benefits as well as side effects and adjust the treatment accordingly.

Behavioral Approaches

Behavioral approaches often can be quite helpful in managing difficult nursing home patients. For example, wandering behavior can be very troublesome in a nursing home setting and generally does not respond well to attempts at chemical sedation. A behavioral approach was taken by Snyder et al (13) in a study that compared eight randomly selected nursing home residents described as wanderers with eight non-wanderers matched on the basis of sex, level of care, nursing unit, length-of-stay at current level of care, mode of ambulation, vision, hearing and mental status. From a time-in-motion study they showed that, as expected, wanderers did move about more frequently and at greater distances than did non-wanderers. Wanderers had significantly greater involvement in "non-social" behavior, defined as behavior that occurs alone and not directly or indirectly oriented to others. Wanderers also tended to spend more time than non-wanderers in behavior such as calling out, screaming, etc. Comparing all wanderers in the facility with all non-wanderers, no difference was found between the groups on age, sex, marital status or diagnosis of heart disease or stroke. Wanderers had lower scores on the Kahn-Goldfarb Mental Status Questionnaire and were more likely to be diagnosed as having organic brain syndrome. There was no difference in length of stay in one's present room; thus, newness or unfamiliarity was not associated with wandering. The authors identified three types of wandering behavior: 1) overtly goal-directed/searching behavior; 2) overtly goal-directed/industrious behavior; 3) apparently nongoal-directed behavior. In addition, they suggested that three psychosocial factors may influence the tendency to wander: 1) life-long patterns of coping with stress; 2) previous work roles; 3) search for security.

The authors suggested various approaches to deal with the wandering behavior. Rehabilitation approaches include efforts to orient the person, to visit previous reference points in the community, to provide a vigorous schedule of physical and social activities, and to relieve anxiety. Compensatory approaches include the use of environmental cues, such as

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signs, and environmental design, such as sheltered courts. The authors also discussed a variety of management implications, including establishing care plans and staff meetings to heighten staff awareness; charting residents' nonverbal behavior, mood and time of wandering; dealing with the special problem of patients who wander away from the facility; and, finally, utilizing drugs and restraints. They recommended a number of alternatives to manage various types of wandering behavior and reported that, at the study facility, wandering subsided to a minimal level after some changes in policy and staff response. Such an in-depth study of a particular problem behavior provides a richness of information on the nature of the problem and how to deal with it. It would be useful to have more such descriptive studies of wandering as well as of assaultiveness or of calling out and screaming behavior. In addition, management interventions should be studied. Snyder et al opposed the use of physical restraints such as belts or geriatric wheelchairs which, in some cases, may increase agitation. The authors did not address what happens to wandering behavior in a locked facility. Such a study could better inform public policy on licensing facilities. Some wanderers might be less disturbed and less disturbing if they could be in a locked facility. However, at present, no community alternative to a locked psychiatric ward exists for these patients. Further exploration of these issues is needed.

In a more recent paper, Rader (14) described a specific comprehensive program that decreased problematic wandering in a nursing home. The first step identified patients with potential wandering behavior from the admission history or observations during the first few days in the nursing home. Such residents were given a special identification bracelet listing their name and a phone number to call if they were lost. All staff were alerted to the potential wandering behavior of the resident, and photographs identifying the resident were posted in the facility A second intervention included the development of activities specifically designed for cognitively impaired residents. A program of music, exercise, and touching was designed and administered in a small group setting for an hour three times a week. Nursing staff came to appreciate that regular walking experiences and activities were an essential part of the care plan for these residents. The third approach involved teaching staff more helpful ways to interact with cognitively impaired residents. Concrete, simple, and exact instructions were most effective. On a nonverbal level, staff were educated to use a gentle, calm tone of voice and physical stroking to quiet a confused person instead of getting angry and shouting which only increased agitation. Staff were encouraged, when possible, to accompany} patients for short walks out of the facility, rather than forcing the confused resident to stay inside. Attempts were made to understand the feelings and needs underlying wandering behavior such as a desire to go "home." Discussion that focused on the resident's family could restore a patient's sense of being cared for and useful. The fourth approach established a specific set of procedures to use when a resident was thought to be missing from his unit. Over a three year period, the use of these approaches increased the safety of the patients at little extra time or cost.

The staff experienced an increased sense of mastery and skill in dealing with confused residents. Fewer combative episodes and staff injuries, and a decrease in the use of physical or chemical restraints were noted. Rader described a particularly poignant case example that illustrates a psychotherapeutic as well as behavioral approach:

> "An 88 year old woman suffered from Alzheimer's disease and Parkinson's disease but was still able to walk unaccompanied for short distances with a walker. She had been a resident for 9 months and had only attempted to leave the building on one recent previous occasion. At that time, the staff stopped her, precipitating 3 days of agitated, restless, and angry behavior. Four days later on a sunny, but cold, winter day she again mistook it to be summer and felt compelled to return to her apartment to visit her sister and to work in her garden. At first, the staff tried to dissuade her because of the cold. Nothing could be said to convince her that it was not summer. So she was accompanied outside and allowed to travel in the direction she wished. The staff person merely followed her lead and provided safety information as needed. Several times, Mrs. D. tried to convince the staff person to go inside as, it was cold and no sense in two of us being lost. The staff member assured her that she had the time and was willing to be lost with her (not an easy thing for staff to do, but a critical point). She was becoming fatigued, chilled and bewildered because she didn't know in which direction her home lay. On noticing this, the staff member asked if she wished to go inside to warm up and rest, with the assurance that, if she wished to, she could return to her searching. She willingly went inside but was in an unfamiliar end of the building. As the staff member and resident were greeted by name, she turned to the staff member and asked, "Do you know these people?" Skillfully the staff member replied, "Yes, and I can take you to a place where you will recognize people and things. Would you like to go?" She responded affirmatively. At this point, a real sadness was coming over her as she began to realize her disorientation. As the two walked to the end of the building near her room, she recognized some of the staff and as she approached her room said with great surprise, There's my room. She then turned to the staff person and with great fatigue and sadness on her face asked, What should I do now? She was told to rest on her bed and that supper would be brought to her shortly. She said, Thank you, and fell asleep. She had no agitation or restlessness following this episode, and this exit seeking behavior did not recur for many months." (14)

A behavioral approach has also been described in a case of late life paranoia (15). An elderly nursing home resident expressed extreme anxiety and fear that she would be murdered. An analysis of the situation revealed deficits of moderate hearing loss (for which she refused to wear a hearing aid) and confinement to a wheelchair, as well as assets of good conversational skills, good lip reading ability and a willingness to assist staff and feed other patients. Staff were uncomfortable with her paranoid verbalizations but responded with avoidance, confrontation, reassurance and, at times, agreement. This periodic agreement was felt to reinforce and maintain her verbal behavior. A treatment program was designed consisting of 14 weekly individual sessions and two staff training sessions in an attempt to modify their interactions with the patient. After establishing a trusting, predictable relationship in which the patient could verbalize her fears, it became possible to correct misinterpretations of everyday events which had led to her paranoid beliefs. Positive reinforcement was provided for her help to other residents. At the end of the treatment sessions, the patient rarely spoke of her fear of being murdered and, when she did, she showed little anxiety. She also became more assertive with staff members when requesting assistance. Involving the staff in the program led to more consistent and effective interaction with the patient and provided them with a more comfortable way to deal with a difficult situation.

Psychotherapeutic Approaches

The use of psychotherapy in nursing home settings to date has been rather limited. Psychiatric consultants willing to venture into nursing homes usually had only a limited amount of time and were asked to help with the management of many behavioral problems. This did not permit therapy sessions with individual residents for 25 or 50 minutes on a regular basis. Until recent changes in Medicare, a net limit of $250 per year for outpatient psychiatric services meant that, at most, 8 therapy hours were covered albeit at a lower fee than that paid by other insurance. The new limit for outpatient psychotherapy of a net $1100 per year (after an effective 50% copayment) may make it financially feasible for psychiatrists to travel from their offices to provide therapy in nursing homes. One other barrier, however, has been the psychoanalytic view that older persons, in general, are not good candidates for psychotherapy. Freud and others felt that early

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childhood experiences were most important and that such memories would fade by late life. That view has been challenged in recent years, however, and there has been an upsurge in interest in psychotherapy for older persons and a growing recognition of its value (16,17,18).

While the number of studies that have examined psychotherapy conducted with nursing home residents is limited, several are worthy of discussion. Goldfarb and Sheps (19) described psychotherapeutic work in a large home for the aged. Therapy consisted of 5 to 15 minute sessions spaced far apart. Each session was structured to leave the patient with a sense of triumph or victory by having won an ally. This approach was designed to help manage the fear and rage that arose in the context of the resident's increasing helplessness and loss of physical, social, and economic resources. The goal was to encourage feelings of mastery in the resident.

Power and McCarron (20) described a controlled outcome study of a brief psychotherapeutic intervention for withdrawn, apathetic, mostly bed or chair-fast elderly patients. The treatment, described as an interactive-contact approach, emphasized interpersonal stimulation. Physical touch, warmth, verbal and affective expressions of personal interest, and the sharing of simple nurturing tasks were construed as the therapeutic elements. Patients were 30 nursing home residents, with a mean age of 84 years. Fifteen were assigned to the treatment condition, and 15 to the control condition. Treatment was continued for 15 weeks. Candidates were identified by depression scores on the Brief Psychiatric Rating Scale (BPRS), completed by the nursing home staff. Clinical diagnoses were not made. Subjects completed the Zung Self-Rated Depression Scale (SDS) before and after treatment, and six weeks after termination. Staff ratings, using the BPRS, were repeated at these two times as well. Results showed significantly lower BPRS and Zung scores for the treated groups than for controls at the end of treatment and at follow-up. This finding suggests that a brief intervention (average 7 1/2 hours of treatment per patient) may have a relatively durable effect. However, scores on both BPRS and SDS were low even during the pre-treatment period, suggesting that these patients were behaviorally disengaged, rather than clinically disturbed or depressed. The results of this study probably have more relevance to issues of understimulation in the institutional setting than to treatment of psychiatric disorder per se. However, any controlled study of therapeutic interventions in the nursing home setting is welcome, and lays valuable groundwork for further work.

Nursing home residents without cognitive impairment can benefit from 50 minute psychotherapy as well as elderly patients in the community. For demented patients, brief sessions can be valuable as illustrated by the following vignettes:

> ** Following her husband's death, an 82 year old moderately demented woman was unable to live at home, even with live-in help. Her family arranged admission to an elegant nursing home but she was often agitated and distressed. Her behavior became so assaultive that she was admitted to a psychiatric hospital. In that setting she was able to participate in some activities that enhanced her self esteem. However, what seemed most helpful was brief (15 minute) daily psychotherapy sessions in which she was able to discuss her husband, to say how much she missed him, and to cry with a therapist who allowed her to express her sad feelings. Each daily session was like starting over because of her poor verbal memory of what had been discussed. However, the affect associated with the memories gradually diminished over time and the therapist became a familiar and trusted friend. The patient's mood improved, her agitation disappeared, and she was able to be discharged to another nursing home. When the therapist visited her regularly there, she felt "at home" and showed him around as if she were the hostess for the whole facility.

> ** An 85 year old single woman lived with her sister her whole life until the sister's death. Because of marked forgetfulness, she became unable to care for herself at home and was admitted to a nursing home. Once there, she repeatedly insisted that she had to go home to look after her sister and, when poseyed, would struggle to untie herself. On one occasion she almost strangled trying to get untied. A behavioral approach to make her feel "at home" was developed. The plan's key element was to have her play the piano daily to entertain herself and the other residents. Despite her moderate dementia, she remembered how to play old songs and enjoyed playing, especially when everyone else joined in singing and told her how wonderful she was. In addition, psychotherapy focussed on helping her accept both the reality of her sister's death (so that she did not feel she had to rush home to look after sister), and the need for nursing home placement. Both were accomplished with daily brief sessions. She was reminded daily that her sister had been sick and had finally passed away. Furthermore, she was at risk when alone because she had left pots on the stove to burn or had gone out in the winter without a coat. Gradually, she was able to accept these realities on an affective level, even though, cognitively, she had to be reminded daily. She also realized that her brother was concerned about her and wanted her to be happy as well as safe. With this emotional acceptance, she was able to make a successful adjustment to the nursing home.

In addition to individual psychotherapy, group therapies also can be very helpful in the nursing home. Herst and Moulton (21) described several types of groups including a new resident's group, a confrontation group, a group formed to deal with issues of loss and grieving, and a life review group. Group members addressed topics such as motivation to live, improvement of memory, social skills, and identity within the nursing home setting.

Moran and Gatz (22) randomly assigned nursing home residents to either a task-oriented group to develop a welcoming project for newly admitted residents or an insight-oriented group that discussed issues of personal concern. These issues included how to get more privacy, to have fun, to help one's children, make friends and gain more control over personal space, diet, possessions, finances, visitors status, noise and roommates. Each group met once a week for twelve 75 minute sessions. A control group was assigned to a waiting list. Pre- and post-treatment subjects were assessed using rating scales for life satisfaction, psychosocial competence, trust, locus of control and social desirability. The task group increased in internal locus of control and life satisfaction. The insight group increased in internal locus of control and in trust. Although a small study, findings showed both group treatments to be superior to the control condition. Furthermore, the nursing home residents commented that they liked the groups and few dropped out.

Staff Consultation and Education

In addition to direct interventions with nursing home residents, a psychiatric consultant can be helpful in designing a therapeutic environment for patients, in helping staff deal with difficult residents, and in educating staff about specific behavioral problems and interventions.

The nursing home environment has the potential for both therapeutic and pathogenic effects. Nursing home residents are socially and physically dependent on caregivers who can encourage independence or foster increased dependence. Barton et al (23) made daily observations of resident/staff interactions over a 23-day period for a group of 17 staff members and 36 patients in a single nursing home. The most frequent patient behaviors were classified as independent, while the most frequent staff behaviors were those supporting dependency rather than independent function. Dependent behaviors of patients were most often followed by dependency-supporting behaviors of staff. The authors conclude that most staff behavior reinforces resident dependent behavior.

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Caporeal et al (24) had elderly caregivers and care receivers judge audio tapes of caregivers interacting with nursing home residents. The results supported the hypothesis that "infantilization" by caregivers can arise from caregiver expectations, that are not always based on the actual functional ability of the nursing home resident. This study is consistent also with the findings of Kiyak and Kahana (25) who studied 72 staff members in four nursing homes using a random behavior sampling technique. The attitudes of the staff about aging and the elderly had previously been ascertained. Data were collected on staff/patient interactions using a checklist of ten behavioral and five affect items; both the content of interactions and the emotions expressed concomitantly were recorded over a series of five minute observations. Staff members' stereotypes about aging predicted their behavior more accurately than did their stated intentions: positive aging stereotypes were associated with positive observed affect and a nurturing, but parental behavioral style; negative feelings about aging tended to correlate with hostile, or at least brusque, interactions with patients. This study highlighted the utility of observational research in nursing homes and suggested areas appropriate for staff training.

Harel (26) examined predictors of well being in fourteen nursing homes in metropolitan Cleveland. A random sample of self-care and intermediate care residents in each home was selected, and 125 valid interviews were obtained. Measures of continuing ties with people outside the facility were significantly associated with all measures of well-being (morale, life satisfaction, and satisfactory treatment). Continuing ties with preferred members of one's social network seems to be more important than having visitors per se. Harel concluded that nursing homes should work to ensure that such contacts are encouraged.

Several techniques were used by Weisberg (27,28) on the floor for mentally impaired residents at the Hebrew Home of Greater Washington. Colorful and eye catching posters were developed to convey something special about each resident on the floor. Personal photos and brief biographies recreated a history for uncommunicative patients, that favorably influenced staff attitudes about them. Social workers regularly spent time working as aides to improve sensitivity to the stresses and challenges faced i by these primary caregivers, which, in turn, improved the morale of aides. Families of patients sponsored an annual "appreciation day" for nurses and aides. While no systematic evaluation was done, the author reported improved interaction between staff and residents, improved staff morale, and enhanced pride of the residents. Residents were seen not as problems but as individuals with unique life histories and accomplishments.

A series of systematic attempts to affect the functioning of nursing home residents by environmental changes were carried out by Langer and associates (29,30,31). In the first study, 91 elderly residents of a large well-regarded facility for the aged were assigned to one of two groups. The first group was offered a plant by the facility administrator and instructed to take care of it. This communication was designed to foster a sense of personal responsibility, efficacy, and pride. The second group was given a plant and told that staff would care for it. This represented a communication of staff's interest in being helpful, meeting needs, and taking care of residents. Outcome measures included self-reports of well being and control, interviewer's ratings of alertness, and nurses' and experimenters' ratings of overall functioning and involvement in activities. Those in the enhanced-responsibility group showed significant improvements on most measures when compared to controls. The authors concluded that some aspects of disability among the frail elderly may be the result of living in a decision-free environment and may be reversible with simple, virtually cost-free changes in the way patients are socialized to the nursing home environment. In a second paper (30) interpersonal or practical incentives were used to motivate nursing home residents to attend to and remember certain aspects of their environment. Using either type of incentive, residents engaged in cognitive activity that resulted in improvement on standard short-term memory tests including probe recall and pattern recall, as well as on ratings of alertness, mental activity, and social adjustment.

Avorn and Langer (31) tested the hypothesis that performance deficits in institutionalized elderly patients may result from social-environmental influences, rather than from disease or aging per se. They used a comparative trial of 3 types of training in a simple puzzle completion task. Subjects were 72 residents of an intermediate care facility; those judged too demented or physically ill to participate were excluded. Subjects were assigned randomly to 3 groups: "helped" (given extensive help in completing the puzzle); "encouraged" (given verbal encouragement); and "no contact." Performance on the task was assessed before and after the intervention period. The performance of subjects receiving assistance deteriorated, while that of subjects receiving verbal encouragement improved significantly. Helped subjects perceived the task as more difficult and themselves as less able to perform than did those receiving encouragement alone. The non-contact controls were intermediate in performance, showing a small practice effect of repetition. The authors concluded that frail elderly patients can be taught to feel and to become incompetent by simple and well-intentioned behavior of their caregivers.

In another study of environmental influences, Schulz and Hanusa (32) tested the hypothesis that the deterioration in health and psychological status among institutionalized elderly may be reversed partially by making a predictable or controllable positive event (visits by a college student) available to them. An earlier study had established that residents who were visited on a predictable and controllable schedule achieved scores on measures of physical and emotional well-being superior to either those receiving visits on a random schedule or those receiving no visits. These same 3 groups were followed up at 24, 30 and 42 months after the intervention to ascertain whether initial gains had been maintained. It was " found that patients in the enhanced-control or predictability groups deteriorated significantly after termination of the experiment, while those in the no-intervention and random-visit groups deteriorated much less. The group that had benefitted most from the intervention did not maintain the initial gains, and the overall status at endpoint was also arguably worse. This raises questions about the long-term value of such brief interventions.

A number of environmental changes have been tried to benefit nursing home residents with Alzheimer's disease. The Long Beach Memorial Nursing Home developed a special program called a "Wanderer's Lounge." (33) From 3 to 5 PM daily, wandering residents are taken to a special room to participate in a program that includes exercise, tossing a ball, refreshments, dancing and a cool-down exercise. Positive changes were noted in each group member in target symptoms such as agitation or incontinence. Cleary et al (34) developed a "Reduced Stimulation Unit" at the Oaknoll Retirement Residence in Iowa City. This unit was designed to reduce the level of stimulation and minimize reliance on memory. As a result of the program, weight loss was curtailed, patient agitation was diminished, restraint use was reduced, and wandering ceased to be a concern of staff or other patients. Family members were highly satisfied with the program and reported that patients were more calm and serene. Finally, Hansen et al (35) developed a Resident Enrichment and Activity Program on a new 30-bed unit for mildly to moderately cognitively impaired residents at the Dallas Home for Jewish Aged. Families were involved actively in the unit's operation and in the care planning for their relatives. They participated in a New Family Meeting, an open house, a mutual support group, quarterly family meetings, family care planning conferences, and a unit newsletter. Family members volunteered to run a variety of activity programs on the unit. Although there was no systematic evaluation of changes in resident behavior, family programming complemented staff efforts to provide a varied and enriched environment and fostered a climate of mutual cooperation and respect between families and staff.

The psychiatric consultant can make use of the above research findings to help nursing homes develop general therapeutic approaches. In addition, the psychiatrist consultant can help staff develop approaches to deal with particularly troublesome residents. Liptzin (36) described a psychiatric consultation requested for an 85 year old widower who had become verbally and physically assaultive to some staff in a nursing home

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when his demands were not instantly met. This man was having difficulty dealing with the loss of independence he experienced when he first was fired from his job at the age of 80 and subsequently sold his house and was admitted to the nursing home. More striking, however was that he had split the staff into those who tried to placate him by meeting his demands (including some sexual ones) and those who set firm limits. The consultant met with the nursing home staff and pointed out the inconsistent staff responses, that encouraged the abuse of staff members who set limits. It was even more striking that the administrator seemed unaware or unconcerned about the physical abuse of staff until the director of nursing explained that staff on the unit were calling in sick or quitting as a result of this patient. At that point, the administrator agreed that something should be done, and the resident was admitted to a psychiatric hospital for evaluation and treatment. Staff were relieved that their complaints had finally been heard. In this case, the psychiatric consultant intervened in a nursing home in which communication channels or structures for resolving conflict were limited. Addressing the systems problems in such an institution had a greater impact in the long run than had the provision of clinical care to the patient referred for evaluation.

Another case example of psychiatric consultation to nursing home staff was provided by Sadavoy and Dorian (37). They described a case of a 71 year old widow who, following a hip fracture, was very difficult to manage in a chronic care hospital. Her personality was similar to patients previously labelled as narcissistically wounded, hateful, special, borderline, manipulative, or difficult. The psychiatric consultants conceptualized the problem with a psychodynamic formulation, developed a plan of intervention including recommendations for management and implemented the plan. The keys to management were: defining what limits were nonnegotiable (such as smoking only in the corridor); writing down the plan clearly and simply; involving a daughter in a constructive way; presenting the plan to the patient as a team including the primary nurse, the head nurse and the primary care physician to prevent splitting; and instituting nursing staff meetings with the consultant psychiatrist. Significant changes occurred in the patient and staff as a result of interventions that addressed the psychiatric needs of the characterologically disturbed patient, something to which most long-term care institutions are not attuned.

Staff consultation also may be necessary and helpful if a serious incident occurs. For example, a psychiatric consultant was called in to a nursing home because a patient was found dead after hanging himself. While aware that the man was depressed and had expressed wishes to die, staff had no experience with such suicidal ideation upon which to draw. It was necessary to give staff an opportunity to discuss feelings of guilt ("how did we let this happen?") and anger ("why was this man admitted here? We're not set up to treat psychiatric patients"). In addition to dealing with their feelings, an in-service education program was developed to address the recognition and management of patients' depression and suicidal behavior. Staff self-esteem, knowledge, and confidence in managing depressed and suicidal patients were enhanced.

Summary

This chapter described the role of the psychiatrist in the assessment and management of individual nursing home residents with emotional, behavioral or cognitive problems. In addition, the psychiatrist can play a useful role in the design of therapeutic environments, particularly by working with nursing home staff to enhance their effectiveness.

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V
PRACTICAL ISSUES

This chapter discusses some of the practical issues involved in developing psychiatric services in nursing homes. These include finding psychiatric consultation, working out an appropriate relationship, paying for the services, and training psychiatrists for work in nursing homes.

Finding Psychiatric Consultation

Most good nursing homes recognize the benefit of having regularly available psychiatric consultation. Awareness of a need for consultation usually starts with direct care nursing staff who deal with problematic behavior or with the Director of Nursing who helps the staff deal with such problems. In addition, psychiatric consultation may also be requested by the attending physicians or Medical Director, by the social worker who handles admissions or deals with family concerns, or by the activities director. The administrator should also be aware that preadmission screening and annual resident assessments are now mandated as a condition of participation in Medicaid and Medicare (Section 4211, Requirements for Nursing Facilities, Omnibus Budget Reconciliation Act of 1987, P.L. 100-203). All individuals applying for or residing in a Medicaid-certified facility must be screened to determine if they have mental illness or mental retardation regardless of either the method of payment or a prior diagnosis of mental illness or mental retardation. For residents with mental illness, an appropriate care plan needs to be developed for those requiring "active treatment." The law requires each state's mental health authority to establish a Pre-Admission Screening and Annual Resident Review process that meets federal requirements. Although, as this Report goes to press, final regulations to implement these particular provisions of P.L. 100-203 are not yet in place, it is clear that nursing homes will have to develop mechanisms to screen residents for mental illness and to provide appropriate care to those found to have mental illness.

In most communities, state funded clinics or community mental health centers will be available to assist in the foregoing process. Chapter III describes examples of programs that have provided psychiatric services to nursing homes. The nursing home administrator should contact the State Mental Health Authority for the name and location of the community mental health center serving the nursing home's catchment area. Although many mental health centers provide useful consultation, very often their psychiatric consultant has limited time available. Given that, most nursing homes should develop a relationship with a private psychiatric consultant. There are a number of ways to go about identifying such a consultant. Some nursing home residents will already be in treatment with a private psychiatrist who might be willing to accept new referrals and make on-site visits to the home. The Medical Director or other attending physicians may have a psychiatrist to whom they refer either from their office practice or when their hospitalized patients develop psychiatric problems. Another alternative would be to contact the local community general hospital or psychiatric hospital to see if staff psychiatrists are willing to consult with the nursing home. Finally, the nursing home could check with the local psychiatric society to obtain a listing of geriatric psychiatrists or could check with the American Association for Geriatric Psychiatry to determine if any AAGP members practice near the nursing home. For practical reasons it is desirable to find a psychiatrist with access to hospital back-up should more acute psychiatric treatment be required.

This section has approached the matter of finding appropriate psychiatric consultation from the perspective of the nursing home. In the next section, issues involved in negotiating the relationship will be described from the perspective of the consulting psychiatrist.

Working out an Appropriate Relationship

Any psychiatrist interested in being a consultant to a nursing home will have to consider some practical issues very carefully. These have been previously discussed by Liptzin (1).

How does one decide to which nursing home or homes one should consult? Sometimes, a nursing home will directly approach a psychiatrist known to be interested in elderly patients. More often, the choice is determined by the homes which accept patients whom the psychiatrist is already treating. For a number of reasons, however, it is usually desirable to have a regular consulting relationship with only a few homes. First, it is very wasteful and inefficient to spend time driving from one home to another to see a single patient at each. It is much more efficient to consult at a facility with a substantial number of patients who require psychiatric services. Second, successful nursing home work requires a substantial investment of time to become acquainted with the staff of the nursing home, including the administrator, the nursing director, the social worker, the activities therapist, the staff nurses, the aides who have the most direct contact with the residents, the attending physicians, and the medical director. It is essential to build a relationship of mutual trust and respect and to learn how to communicate the nature of important observations and those problems in need of urgent attention. Third, it is important in evaluating individual patients to know what is going on in the milieu at the home. Has the home been sold? Has the nursing director quit or been fired? Are there more agency nurses than usual? Has there been a recent resident suicide? All this information is more readily available if the consultant visits regularly. A clinical example will illustrate the importance of these factors:

> An eighty year old man was referred for evaluation of an acute increase in wandering and inappropriate spitting and urinating in the elevator and hallways of the nursing home. Although a resident of the home for over a year, his ability to be "safely" managed was being questioned by the staff. The family had been quite satisfied with his prior adjustment to the home and was distraught that another placement might be necessary. Based on his familiarity with the home, the psychiatric consultant was able to point out that significant staff turnover was largely responsible both for the patient's increase in inappropriate behavior and the new expressions of staff concern. The Administrator had resigned and been replaced. The new Administrator had fired the Director of Nursing and had hired someone with whom he had worked at another facility. The supervisor on the resident's floor had left and been replaced by the previous charge nurse. All of these changes had led to ambiguity about staff expectations of this resident and inconsistency in carrying out the nursing care plan. With the consultant's help, a new plan was developed with clear expectations for a regular toileting schedule, a regular time at night for the man to be on the unit rather than wandering around

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the facility, and a policy of firm return to his room when he urinated or spat on the floor. This plan was communicated to all direct care staff.

Establishing a consultative relationship requires clear agreement on what each party can expect from the other. How available will the consultant be for regular visits or emergencies? How and when can the consultant be reached by telephone? What will the consultant's relationship be with nursing staff and attending physicians? Will the consultant be involved in staff education or program consultation as well as in individual patient-centered consultation? Is the consultant authorized to write orders directly? What documentation in the resident's nursing home chart will be expected? Will the consultant be involved actively in questions about the residents' medical status and treatment, including the ordering of lab tests or medications for medical conditions? Will the consultant be for regular visits or emergencies? How and when can the consultant be reached by telephone? What will the consultant's relationship be with nursing staff and attending physicians? Will the consultant be involved in staff education or program consultation as well as in individual patient-centered consultation? Is the consultant authorized to write orders directly? What documentation in the resident's nursing home chart will be expected? Will the consultant be involved actively in questions about the residents' medical status and treatment, including the ordering of lab tests or medications for medical conditions? Will the consultant meet with or be available to family members by phone? Although it is not necessary to have a written contract spelling out all the details of the consulting arrangement, a clear, mutually agreed upon understanding of all the above issues must exist. Before entering into the relationship, both parties should make sure the consultant's orientation and that of the home are well matched. A consultant primarily interested in psychotherapy should probably not consult at a home looking for a psychopharmacology consultant. However, it is usually possible, over time, to gain the respect and trust of staff to consider approaches other than medication. The consultant and the nursing home need to have an understanding of what arrangements will be possible if a nursing home resident becomes so impaired that a psychiatric hospitalization becomes necessary. It is ideal with respect to ease of admission and continuity of care if the consultant has admitting and treatment privileges at an inpatient psychiatric unit. The consultant also needs to know what insurance, if any, is available to support psychiatric hospitalization. With patients who were discharged, from state mental hospitals who have no hospital insurance benefits, it is often necessary to work out arrangements for rehospitalization either with the local community mental health center or with the state hospital. When a resident is hospitalized, it is extremely helpful to have the nursing home guarantee readmission. With patients who are paying out-of-pocket for the nursing home, this usually means having the patient or family continue to pay for the bed. Unfortunately, for patients on Medicaid, there is no guarantee of payment past 10 days. This often leaves the patient without a place to go when ready to leave the hospital. For the psychiatric consultant, this often means that it is difficult to find a hospital willing to admit the patient in the first place. Frank discussion of these issues and careful planning can usually avoid these unpleasant misunderstandings.

Paying for the Services

A critical aspect of the relationship between the consultant and the nursing home is the financial arrangement. For the consultant, the ideal situation is to be paid a monthly retainer fee by the home and to bill patients for services that are provided directly to them. The retainer covers the time spent discussing cases with the staff or participating in in-service education programs, neither of which can be billed to individual patients. Without a monthly retainer, the psychiatrist is dependent on fees collected from third party payors or out of pocket payments from patients or their families.

How can nursing home consultation be financially viable for a private practitioner? Having a regular time to visit the home can allow for efficient scheduling of new evaluations and follow-up visits. In most cases, scheduled patients will be available at the home so that "no-shows" are minimal. The frequency of visits will depend on the size of the home, the number and type of patients who need to be seen, and the type of treatment provided. Weekly visits are practical if there are a few patients who need regular psychotherapy or frequent medication adjustments. A regular weekly schedule usually obviates the need for emergency visits.

Most nursing home residents are covered for physician's services by Medicare Part B or by Medicaid. Many have some form of supplemental insurance to cover the deductible or coinsurance not paid by Medicare. Some patients or families are willing to pay for any uncovered expenses, especially those who can afford to pay up to $50,000 a year for the nursing home bed. For patients on Medicaid, fees vary widely from state to state. In some states (e.g., Massachusetts) the allowable fees for consultations, initial evaluations or ongoing psychotherapy are essentially identical for Medicare, Medicare and Blue Shield, the largest private health insurer. The maximum benefit for psychiatric services varies with each state Medicaid program while the Medicare benefit is uniform throughout the country. Until recently, the Medicare benefit was limited to 50% payment of expenses for outpatient psychiatric services up to a maximum of $250 per year. That level of benefits was well below that provided by most private insurance and created financial barriers to Medicare patients receiving psychiatric services. In January 1989, that limit was raised to $1100 per year for outpatient psychiatric services. Of particular significance for work in nursing homes is the unlimited benefit (with an 80/20 copayment) for prescription drug management, called "medical management." Further, services for patients with Alzheimer's disease or related disorders are similarly unlimited and provided at the 80-20 copayment ratio. However, it remains to be seen whether medical visit limits in nursing homes will apply. These long-overdue benefit changes mean that Medicare patients, including nursing home residents, now have better benefits for outpatient psychiatric treatment than many younger employed patients.

Training Psychiatrists for Work in Nursing Homes

Increased demand, including more adequate reimbursement for psychiatric services in nursing homes, will require a substantial expansion of training in nursing home settings. To date, nursing homes have not been utilized widely in psychiatric resident training. The National Institute of Mental Health (NIMH) has supported post-residency Fellowship Programs in Geriatric Psychiatry that generally include some required experience in nursing homes. NIMH also has supported Faculty Development Awards in Geriatric Psychiatry and Geriatric Mental Health Academic Awards which have expanded the training opportunities in geriatric psychiatry, including some exposure to nursing homes, for psychiatric residents and medical students.

One example of such a program is at McLean Hospital in Belmont, Massachusetts (2). PGY-III residents in psychiatry have a required 4 month rotation spending one afternoon a week as the psychiatric consultant to an elderly services team at a community mental health center. As part of their work, these residents provide psychiatric consultations to nursing homes. PGY-V Fellows in Geriatric Psychiatry have a required 12 month rotation in the same setting. Another program was described by Jacobson and Juthani (3). Second year psychiatric residents at Bronx-Lebanon Hospital spend one afternoon a week for three months at the Daughters of Jacob Geriatric Center. The average age of the patients is 86, about half have some degree of mental disorder, and 10% are in active psychiatric treatment. Under the supervision of the attending psychiatrist, the resident participates in the pre-admission psychiatric evaluation of selected applicants, in consultation and follow up of patients referred for psychiatric evaluation, in regularly scheduled case conferences, and in staff in-service training. Regular supervised discussions of important issues in aging are supplemented by assigned reading.

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In addition to training of psychiatric residents, nursing homes increasingly are being used to train medical students. Aronheim (4) expressed some concerns that attitudes toward the elderly could be affected adversely by exposing students only to understaffed institutions with impaired or debilitated patients. Students also should be exposed to healthy people over 80 years of age. Aronheim also expressed concern that academizing nursing homes might lead to an inappropriate increase in invasive procedures to learn about illness at the expense of the patient. Other concerns about the increasing number of nursing homes with academic affiliations were expressed by Kapp (5). He raised questions about liability for injuries caused by a student, about patients being asked for informed consent for student participation in their care, about possible substandard care, about confidentiality, and about supervisory responsibilities. Kapp makes several suggestions to address these problems and asserts that it is possible to combine legitimate educational goals with quality care and still fulfill one's legal responsibilities.

Schneider et al (6) documented a remarkable increase in the number of nursing homes with academic affiliations. These affiliations have had clear benefits in terms of new research findings. The "teaching nursing homes" funded around the country by the National Institute on Aging have generally focussed on biomedical research. In commenting on the paper by Schneider et al, Riesenberg (7) notes that nursing home courses are electives taken by very few medical students. He also comments that no positive attitudinal change to older patients has been demonstrated for students who do spend time in nursing homes in contrast to positive attitudes engendered by exposure to healthy community-dwelling elderly. New approaches to medical education need to be found to expose students to the challenges and rewards of treating patients in nursing homes. As these attitudes change generally in academic medical institutions, it will be easier to also provide training in geriatric psychiatry in nursing homes.

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VI
THE PROBLEMS: DISCUSSION AND RECOMMENDA TIONS

The previous chapters have summarized what is currently known about psychiatric, emotional and behavioral problems in nursing homes. Examples of programs for providing psychiatric consultation to nursing homes have been described, as has the key role of the psychiatrist in managing problem patients. This chapter discusses some of the current issues and problems related to nursing homes and makes recommendations for future action.

Nursing homes have received considerable attention from policy makers in the last few years as a result of the report "Improving the Quality of Care in Nursing Homes" published by the Institute of Medicine and culminating in enactment of federal conditions of participation for long term care facilities in the Medicare and Medicaid programs included in P. L. 100-203. The changes include: gradually phasing out the distinction between Skilled Nursing Facilities and Intermediate Care Facilities and establishing a single set of requirements for all nursing home facilities; for all patients a physician visit would be required every 60 days; all facilities would be required to contract with at least a part-time medical director; all facilities with more than 120 beds will be required to have a full-time social worker on staff; round the clock licensed nurses in all facilities with an RN on duty every day; qualified activities directors and dietitians in all facilities; mandatory training for all current and future nurses' aides; and a new emphasis on quality of life and residents' rights including the right to participation in informed decisions about care and treatment; freedom from unnecessary chemical or physical restraints, physical or mental abuse, and involuntary seclusion; privacy; confidentiality; notification of legal rights and responsibilities and of services available; and freedom from involuntary transfer and/or discharge. Comprehensive assessments are required of residents on admission, after any significant change in condition, and annually. These assessments provide the basis for a written plan of care that

> "describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met; is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and is periodically reviewed and revised by such team after each assessment."

The goal is to "maintain the highest practicable physical, mental and psychosocial well-being of each resident." One other major new provision, effective January I, 1989, requires the preadmission screening of all "mentally ill" and "mentally retarded" individuals to assure that they require the level of services provided by a nursing facility and do not require "active treatment" for their condition. Beginning April I, 1990, each "mentally ill" or "mentally retarded" resident of a nursing facility must have an annual review to determine if care in the nursing facility is still required or if inpatient psychiatric services are needed. A resident is considered "mentally ill" if the individual "has a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder)." The determinations as to who is "mentally ill" and whether they { can be appropriately managed in a nursing home is to be made by "the State mental health authority (based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority". The law also requires that states adjust their Medicaid rates to support all these new requirements.

At the time of this Report's publication, the Department of Health and Human Services has issued partial final regulations for review and comment. However, the Department has not yet promulgated draft or final regulations or instructions to implement provisions relating to preadmission screening and resident review. Nonetheless, the required changes in nursing facilities will be substantial, and many unanticipated changes may result.

The nursing home reform law has raised many issues related to the care of the "mentally ill elderly" in nursing homes. From a psychiatric perspective, several problems with the law should be addressed. These problems and a number of other problems highlighted in the current report are identified here.

PROBLEM 1. *More specific data are required on the extent and types of behavioral and emotional disturbances experienced by nursing home residents.*

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DISCUSSION: Chapter 1 summarized existing studies in this area which clearly document that large numbers of nursing home residents have psychiatric or behavioral problems. A great deal more information is needed to address issues such as: I) How many current nursing home residents have had longstanding psychiatric problems or were transferred from a mental hospital to the nursing home? 2) How many nursing home residents have acute psychiatric problems? 3) How many residents have behavioral disturbances as a result of a psychiatric illness, including progressive dementing disorders? Such data are essential to plan and operate appropriate programs, including decisions about staffing patterns (e.g., how many hours of skilled nursing time or psychiatric consultation are needed for a particular type of facility?) It is unclear from the language in P.L 100-203 whether all potential nursing home residents, or only those patients admitted directly from psychiatric treatment programs, require a pre-admission psychiatric evaluation. Answers to the above "' questions will be very helpful in formulating future policies for nursing homes.

RECOMMENDATIONS:

1. The National Institute of Mental Health (NIMH) should assure that available data from the institutionalized elderly sample of the Epidemiological Catchment Area (ECA) program are properly analyzed and published. Rationale: These data already exist and, although methodological problems need to be resolved, the data represent a rich source that should be utilized as much as possible.

2. The National Nursing Home Survey carried out periodically by the National Center for Health Statistics should include questions on psychiatric, emotional and behavioral disturbances in nursing home residents. Rationale: This major national study provides a great deal of useful data on the characteristics of nursing homes and their residents. It should be possible, at modest cost, to add questions to this existing survey that collect information relevant to policies regarding psychiatric care of nursing home residents.

3. NIMH or other federal agencies should support further development of practical epidemiologic instruments both suitable for a nursing home setting/population and focused on psychiatric, emotional and behavioral disturbances. Such instruments should be suitable for determining the presence and severity of psychiatric symptoms and be suitable for treatment outcome studies. Rationale: Existing epidemiologic instruments either are designed for the psychiatric problems of younger patients or are not suitable for a frail, institutionalized population with complex combinations of medical, neurologic and psychiatric disorders and functional disabilities. This is particularly evident for measures of treatment outcome.

4. NIMH or other federal agencies should support further epidemiologic research focused on emotional, behavioral and physical problems of nursing home residents as well as nursing home research of residents with specific DSM-III-R diagnoses such as major depression. Rationale: While the National Nursing Home Survey and the ECA Study can provide sample data on large populations, they cannot provide the required indepth assessments of individuals necessary to untangle the complex interplay of psychiatric, medical and psychosocial factors in the disturbances of nursing home residents. More specific data are needed to define which patients benefit most from psychiatric interventions.

PROBLEM 2. *Former mental hospital patients in nursing homes are often improperly placed and may not receive adequate psychiatric and rehabilitative services.*

DISCUSSION: Studies reviewed in Chapter 2 have demonstrated clearly that some former mental hospital patients can function quite well in specific nursing home settings. However, other patients do poorly and do not receive needed psychiatric services. Needed services may not be reimbursable through health insurance, or may not be provided by State-funded mental health programs. Furthermore, the Medicaid law has prohibited nursing homes from specializing in the care of mentally ill patients. In many cases, nursing homes are used for placement in the absence of alternative facilities, such as halfway houses or community residences. This is particularly inappropriate for younger chronic patients, but is applicable to older chronic patients as well. Such placements may, be prohibited under P.L. 100-203, and, without the development of the alternate facilities, patients may be forced to remain in state mental hospitals.

RECOMMENDATIONS:

1. NIMH and other appropriate federal agencies in partnership with state mental health agencies should support careful follow-up studies of former mental hospital patients to ascertain which ones do or do not do well in which types of nursing homes or alternate setting. Rationale: More knowledge is needed in order to make better informed public policy with respect to former mental hospital patients and others with long term mental illness. The federal government has had the major role in funding such research. However, given the significant role of the states in providing services for the mentally ill, it is important that these studies be undertaken in federal-state partnership.

2. Congress should amend the Medicaid law to establish a new category of nursing care facilities for the mentally ill. Rationale: Current Medicaid law precludes reimbursement for nursing homes that wish to specialize in the care of the mentally ill. The creation of this new class of facilities would allow such programs to develop, as they have in the case of the mentally retarded. Standards for such facilities would be more specific in the areas of psychiatric and rehabilitative services so that more appropriate care could be provided than in the usual community nursing home.

3. State mental health agencies should undertake psychiatric nursing home pilot programs that are adequately staffed and funded, and which provide hospital backup when needed. Rationale: Prior to the amendment recommended above, states could and should develop pilot programs with a Medicaid waiver. Such models were described in Chapter 3 but need to be replicated and expanded.

4. State mental health agencies should assure that psychiatric follow-up and consultation services to nursing homes are provided for former mental hospital patients. Rationale: States have the primary responsibility for the funding and provision of services to the long term mentally ill. Previously, regulations for federally funded Community Mental Health Centers required follow-up and consultation services to nursing homes. However, with the shift to funding by block grants to the states, these services are no longer required. P.L. 100-203 does require the State mental health authority to play an important role in pre-admission screening and annual reviews of nursing home residents with "mental illness", not just former mental hospital patients. However, assuring that needed psychiatric services are provided will help prevent unnecessary re-hospitalization of former mental hospital patients.

5. State mental health agencies should assure that hospital backup is available for nursing home residents who are unmanageable, particularly if they are former State mental hospital patients. Rationale: Many nursing homes are reluctant to admit patients from mental hospitals due to concern that such patients may become acutely disturbed and will require hospitalization which may be difficult to arrange. Appropriate backup will make nursing homes more willing to accept patients with acute or chronic psychiatric disturbance that they are able to manage.

PROBLEM 3. *More information is needed on which interventions are useful in nursing home settings*.

DISCUSSION: Clinical experience indicates that all modalities of psychiatric treatment can be effective in geriatric patients. However, as summarized in Chapter 4, very few studies have evaluated specific interventions used with nursing home residents. Studies of specific medications rarely include frail elderly patients and almost never include nursing home residents. Furthermore, psychosocial or behavioral interventions that may work in a hospital setting may be impossible or ineffective in a nursing home setting that has fewer and less well trained staff. Too little is known about the nursing home environment and its effects on mental functioning and well-being. Further knowledge is critical

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to understand which residents with mental illness can be managed in a nursing home setting and which require "active treatment" in a psychiatric hospital. Such studies can also help target interventions to nursing home residents most likely to benefit.

RECOMMENDATIONS:

1. NIMH and other federal agencies should stimulate and support research on behavioral, psychosocial, pharmacologic and environmental interventions in nursing homes. Rationale: The federal government has historically funded research of this kind and is in a position to stimulate interest through specific research conferences or specific funding announcements. The field would also benefit from development of carefully designed collaborative studies in nursing homes.

2. Psychiatric researchers should conduct more research in nursing home settings. Rationale: Although practical problems are raised by attempting research in nursing home settings, these must be overcome to develop effective interventions for frail nursing home residents. Such research could be carried out in existing teaching nursing homes although results from these well-staffed, academically-affiliated institutions may not be generalizable to community nursing homes. Clinical psychiatric consultants to nursing homes who wish to participate in research will need assistance in study design and data analysis from experienced researchers.

PROBLEM 4. *Existing programs for providing psychiatric services to nursing homes have not been adequately documented or evaluated.*

DISCUSSION: Chapter 3 described a number of programs for providing services to nursing homes. However, these are largely anecdotal reports without rigorous outcome measures. Furthermore, they almost never include measures of cost -effectiveness which would allow policy makers to choose among competing alternatives. Such studies would be of great benefit.

RECOMMENDATIONS:

1. NIMH, other federal agencies, or private foundations should fund demonstrations with careful program evaluations of models for delivering psychiatric services to nursing homes, to see which are most cost-effective and for which types of patients. Rationale: There are few well-studied models of nursing homes with appropriate psychiatric services. Demonstrations and evaluations similar to those funded by the Robert Wood Johnson Foundation of day care for Alzheimer's patients should be supported by the federal government or by foundations.

PROBLEM 5. *Too little is known about the effects of the nursing home environment on resident well-being; current regulations that attempt to address quality of life issues are based on limited data.*

DISCUSSION: As discussed in Chapter 4, few studies address how the nursing home environment affects the physical and emotional well-being of residents, even though the environment may be a powerful determinant of well-being and quality of life. More extensive research data will be helpful in identifying environmental considerations that should be incorporated into program design or regulation and in evaluating the effects of recently enacted federal requirements.

RECOMMENDATIONS:

1. NIMH and other federal agencies should support studies on the effects of the nursing home environment on resident well-being. Rationale: This is an important area of research, and the federal government traditionally has provided research support for such studies.

2. The Health Care Financing Administration should incorporate into nursing home regulations existing knowledge on the effects of the nursing home environment on resident well-being and should carefully evaluate such regulations for their costs and adverse impacts as well as benefits. Rationale: Previous regulations addressed some environmental issues, such as food service and cleanliness. New regulations will address the important areas of resident rights which should enhance patient autonomy or choice. However, the ultimate effects of these regulations are unknown and need to be studied. This is particularly important since such patient rights as freedom from the use of restraints has a different meaning in a nursing home with frail, cognitively impaired residents than in a mental hospital. There needs to be a careful balancing of patient autonomy with patient safety.

PROBLEM 6. *Too few health care professionals or providers, including mental health professionals, have received sufficient training in nursing home settings or caring for nursing home residents.*

DISCUSSION: The lack of awareness of nursing home issues among health professionals has been well documented. The National Institute on Aging attempted to address these issues by developing a small number of Teaching Nursing Homes around the country. While these programs have carried out some teaching and considerable research in nursing homes, they generally have not addressed psychiatric problems. The NIMH, through its clinical training programs and Faculty Development Awards in aging, has incorporated some nursing home experience into the programs at a small number of medical and other health professional schools. However, few programs are currently funded, and future funding is uncertain.

RECOMMENDATIONS:

1. NIMH and other federal agencies should encourage education and training of health professionals in nursing home settings. Rationale: Although NIMH no longer is funding clinical training programs directly, efforts to develop geriatric faculty should include required exposure to nursing home settings. Geriatric Education Centers funded by the Health Resources and Services Administration provide a resource to develop an increasing cadre of faculty who can teach in and about nursing homes.

2. Health professional schools, particularly medical schools, should develop elective and required experiences in nursing homes for their students. Departments of Psychiatry should be involved actively in these developments. Rationale: In order to prepare their students for a future career which is likely to involve caring for the increasing number of elderly, many of whom will be in nursing homes, educational experiences in these settings will be important. Psychiatric education needs to be a major focus of these experiences.

PROBLEM 7. *More psychiatrists are needed to provide services to nursing home residents with psychiatric, emotional or behavioral disturbances*.

DISCUSSION: As noted above, a greater number of psychiatrists need to be trained to work with the elderly generally, and with nursing home residents in particular. Unfortunately, this is not an area of practice with high financial rewards. Current reimbursement policies, even with the improvement in the $250 annual limit on outpatient psychiatric services, provide inadequate reimbursement and thus, restrict the availability of psychiatric services to elderly patients. In nursing home settings, travel time further reduces the already inadequate level of reimbursement.

RECOMMENDATIONS:

1. In order to encourage nursing home visits, the Health Care Financing Administration should raise fees for visits to nursing homes for psychiatrists and other physicians. Rationale: Even with the increase in outpatient psychiatric benefits under Medicare, financial incentives to encourage psychiatrists to provide services in nursing homes remain low.

2. State rate-setting agencies should include psychiatric consultation as an allowable nursing home cost and should build it into the Medicaid daily rate at a minimum of 8 hours per month per 100 beds. Rationale: In addition to providing psychiatric services to individual patients, a psychiatric consultant should be available to nursing home staff for in-service education and general discussion of psychiatric issues in the residents without billing individual residents.

PROBLEM 8. *New requirements for pre-admission screening may make it more difficult for any patient with a history of mental illness to be admitted to a nursing home.*

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DISCUSSION: The new requirements for pre-admission screening under P.L. 100-203 had the laudable goal of avoiding placement of patients in nursing homes who were too psychiatrically disturbed to be managed there. However, unless every potential nursing home resident is screened and clear criteria developed for who requires active psychiatric treatment, it is quite possible that patients with any past history of mental illness will be discriminated against even if their "mental illness" is quite stable.

RECOMMENDATIONS:

1. HCFA should continue to seek appropriate psychiatric input to assure that regulations to implement the pre-admission screening requirements are applied fairly and with a clear understanding of the wide range of "mental illnesses," most of which can be adequately managed in a nursing home. Rationale: Psychiatrists with experience in nursing home settings can help clarify which dysfunctional behaviors rather than "mental illnesses" cannot be managed in a nursing home but rather require treatment in a psychiatric hospital.

2. State mental health authorities should carefully monitor the implementation of the pre-admission screening requirements to evaluate its effects on the admission of persons with "mental illness". Rationale: State mental health authorities were given the responsibility for assuring that preadmission screening is done. In addition, many elderly patients are evaluated and treated in the State mental health system so that the State authority will have an interest in assuring that nursing home placements are available for individuals with mental illness who do not require psychiatric hospitalization.

CONCLUDING REMARKS

In summary, recent years have seen more attention paid to the care received by the 1.4 million Americans who reside in nursing homes, most of which is paid for through public sources. This report has highlighted the high prevalence of psychiatric, behavioral, emotional and cognitive problems in elderly nursing home residents and the important role that the psychiatrist can play in the evaluation and management of such patients. More research is needed to understand the full nature of the problems and the best ways to manage them. Better training of health care professionals is needed to prepare them for work in nursing home settings. Collaboration is needed among all levels of government and between the public and private sectors to improve the financing and organization of services for nursing home residents, particularly those with psychiatric problems. The Task Force hopes this report can be a useful addition to the ongoing public dialogue on how to improve the care of nursing home residents.

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