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When Mental Illness and Aging Make Nursing Homes Necessary: What Next?

Joanne Kaldy

Do people with chronic mental illness belong in nursing homes?

Although opinions might be divided, in reality some mentally ill patients do end up in nursing homes. Their illnesses range from major depression and bipolar disorder to anxiety-related illness and schizophrenia, all of which require individualized care and special treatment.

Nursing homes need to plan to see more chronically mentally ill residents in the coming years. "We are seeing more of these patients in this setting. As little as 5 years ago, we said that those with chronic mental illness died 25 years before those without. That isn't true anymore," said Maureen Nash, MD, MS, medical director of the Providence ElderPlace Oregon Program of All Inclusive Care for the Elderly (PACE). As a result, more of these patients are living into their 60s and beyond, and they are experiencing age-related diseases and disabilities that mental health facilities and community-based group homes are unable to manage. "We need to focus a little more attention and a little less stigma on this population," she said.



Nursing homes should plan now if and how they will accommodate a growing population of mentally ill individuals.

Institutions to Independence
Up through the 1960s and 1970s, state mental hospitals housed the majority of people with chronic mental illnesses. However, policymakers in the early

1980s determined that some of these individuals could be better served by integrating them in the community.

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Intervention to Reduce Antipsychotic Use May Have Moved Needle

Christine Kilgore

Nursing homes exposed to a comprehensive web-based educational program on the appropriateness of antipsychotic drugs in dementia patients — as well as to the Centers for Medicare & Medicaid Services Partnership to Improve Dementia Care (CMS Partnership) — appeared to have modestly reduced antipsychotic and anticholinergic use without an ad-

verse effect on symptoms, according to a recent evaluation of these programs' impact.

Researchers used assessment data from the Minimum Data Set (MDS), Medicare, and other sources for Iowa nursing home residents from 2011 and 2012 to try to evaluate the impact of a training program and toolkit of clinical decision aids. The resources include an

algorithm for treating the behavioral and psychological symptoms of dementia (BPSD), a tip sheet for managing a behavioral crisis, and laminated pocket guides. In addition to the web-based training, the content was delivered through presentations at professional meetings.

See **INTERVENTION** • page 14



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Mental Illness

from page 1

“A pitch was made that it would be kinder, more medically appropriate, and more cost-effective to de-institutionalize many of these patients,” said David Smith, MD, CMD, president of Geriatric Consultants in Brownwood, TX. Many saw this as a positive, especially since mental hospitals had a generally bad image from movies such as *The Snake Pit* (1948), which depicted these facilities as places of abuse and neglect. “These kinds of portrayals were game-changers that really influenced public perceptions about mental hospitals, so people eagerly embraced the idea that de-institutionalization would be more humane,” he said.

Others were not so sure and expressed concerns about what would happen to these individuals. For example, Dr. Smith recalled, the National Association of State Mental Health Program Directors suggested there was a risk that these people would end up in nursing homes, which would not be equipped or prepared to deal with their special needs. The organization led a lobbying effort that resulted in the establishment of the federally

mandated Pre-Admission Screening and Resident Review (PASRR) program, which requires that all states prescreen all individuals seeking admission to a Medicaid-certified nursing facility.

PASRR screening is designed to identify people with mental illness, intellectual disability, developmental disability, or related conditions, and to identify alternative placement options and specialized services that the person may need. PASRR was supposed to enable more people with mental illness to live in the community — in group homes, with families, or even independently — and to stay out of institutions. Unfortunately, as Dr. Smith noted, a large number of patients just moved from state institutions to nursing homes or ended up living on the streets — the very situations PASRR was intended to prevent. As a result, nursing facilities and community organizations have had to scramble to find ways to address the needs of individuals with mental illnesses.

Tackling a New Challenge

A nursing facility may be equipped to care for age-related illnesses and conditions, such as arthritis, heart disease, or kidney disease, but the staff often have limited experience dealing with

individuals with chronic serious mental illnesses, whose needs are different. They tend to be younger, and they have different privacy expectations. They often have a history of nicotine, alcohol and illicit drug abuse, said Dr. Nash; as they age, they are likely to have illnesses related to these excesses.

“Surveyors consider a secure unit [to be] appropriate for patients with elopement issues, but not for someone with schizophrenia.... If you put these residents in such a unit, surveyors are likely to consider the locked doors unnecessary restriction.”

Although nursing homes have experience managing patients with dementia and related behavioral issues as well as mental illnesses such as depression, they are not inherently equipped with the staffing or tools to provide optimal care for patients with mental illnesses such as bipolar disorder or schizophrenia. The facilities that take these patients without ensuring they have adequate staffing by trained and experienced professionals may be putting themselves at risk.

“These patients may get into altercations with other residents or staff, the facility may see more citations, and their reputations may suffer,” Dr. Smith told *Caring*.

Establishing a separate unit for residents with mental illness is a possible solution. However, “surveyors consider a secure unit [to be] appropriate for patients with elopement issues, but not for someone with schizophrenia or other issues,” Dr. Smith said. “If you put these residents in such a unit, surveyors are likely to consider the locked doors unnecessary restriction.” Additionally, many facilities aren’t designed or built in a way to accommodate a separate unit for a new patient population.

Sometimes, Dr. Nash noted, facilities are hesitant to accept patients with chronic mental illness. “People are being discriminated against and stuck in hospital beds they don’t need,” she told *Caring*. She urged medical directors and other team leaders to look at the past as the best predictor for the future. “If someone with chronic mental illness is taking his or her medications and doing well, you can go by that. Focus on what really is a risk and what isn’t.”

Behavior Management

Nursing homes can apply their experience and knowledge of managing behavioral issues in patients with dementia. For instance, said Dr. Nash,

“Look at what triggers people.” Get to know these individuals, she suggested, including their fears, phobias, likes, and dislikes. When patients with chronic mental illness are getting appropriate treatments and are compliant, behavioral issues are less likely to be problematic if the staff know the resident.

Nonetheless, some staff may have fears and concerns. “I sat at a meeting once where someone said that no one with schizophrenia should live in a nursing home,” Dr. Nash said. “I told her that she probably has neighbors with the illness, and she doesn’t even realize it. You need to identify and address fearfulness, prejudices, and lack of accurate knowledge and information among caregivers and others.” She suggested addressing these issues frankly and openly.

“Bring staff together and ask what kinds of problems people would expect patients with schizophrenia, manic depression, or other mental illness to have. Talk about the misconceptions and fears people in general have and how staff can help address these,” Dr. Nash said. “Modeling is the best approach. Find out who on staff has a relative or friend with mental illness who is willing to share their stories. Don’t force them to do this, but give them the opportunity to educate and share with others.”

Facilities need to acknowledge that their current staff — however capable — may not have the skills and training to deal with chronic mental illness. “When you recognize that staff are really part of the environment of the organization, you can employ environmental awareness and related education. You need to have a safe place not on the wards where staff can talk,” said Dr. Nash. It is key, she noted, not to expect staff to do things they can’t. She added that assessing staff readiness to change is important, as “people won’t change if they don’t see a need for or value in it. They are only open to change when they see a problem that change can solve or effectively address.”

Nursing and other staff shouldn’t be forced to work with residents who have serious mental illnesses. Instead, suggested Dr. Smith, they should have the opportunity to make this choice, and then they should get the training, information, and tools they need to be confident and successful in this role.

Dr. Smith suggested vetting potential staff for these residents carefully. “You have to screen out people who are attracted to this work because they like having power over others or because they want to be saviors or heroes. Staff need to come in with an understanding of the reality of what they are choosing to do.”

It may be necessary to bring in staff with specific experience working in psych units. However, Dr. Smith said, “Internally, over time, you get to know your staff and recognize those with

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unique interpersonal skills to work with this challenging patient population.

“There is no place where teamwork is more important than when working with people who have mental illness and medical comorbidities,” he added. “You really need your interdisciplinary team. You need to cultivate your [certified nursing assistants] and mine them for information. They can tell you the nuances of what is going on. They may not understand the pathology of the illnesses, but they see the nuts and bolts of what is happening with a resident and what is setting him or her off.”

Partnerships or other relationships with geriatric psychiatrists have great value, but don't count on those exclusively, Dr. Nash said. “There have been a lowered number of slots for psychiatry in training programs for 40 years or so, and this has created a shortage that is here to stay. We need to move people away from one-on-one treatment into group therapy and interventions such as occupational therapy.” Occupational therapists, she said, “can assess a person's actual level of functioning and help people address their deficits.”

A Team Decision

Ultimately, the decision about whether to accept any resident with mental illness should involve the medical director and other team leaders.

“I have facilities ask me to look over the record of a potential resident,” Dr. Smith said. Particularly if the person is coming from another nursing facility, “you really have to dig into the nursing notes for a couple of weeks and read between the lines. You need to look at why the facility is transferring this resident,” he said. Family members may mask or downplay a patient's condition or history to get him or her into a facility, so it is important to have an experienced physician or other practitioner who can talk to these people, identify any red flags, and uncover any hidden problems or issues, he said.

Community partnerships are essential if a facility is going to take patients with chronic mental illnesses. “It is very important to have a relationship with the mental health community in the area. And you need to make an effort to find a social worker with experience in this field and who has a strong network of contacts to address any emergent situations or issues that arise,” Dr. Smith said.

The Drug Dilemma

In a world where post-acute and long-term care facilities are under pressure to reduce the use of antipsychotic medications, patients with chronic mental illnesses may present a challenge.

“I care about the appropriate treatment for the person in front of me. I want someone who needs antipsychotic medication to get it,” Dr. Nash said, and that includes many patients with chronic mental illness. “Quality metrics for antipsychotics involves a blanket rate of use and doesn't address the fact that these drugs are needed for illnesses such as bipolar and some recurrent major depressions,” she said.

Antipsychotic use must be employed and assessed on an individual basis, she said, in which these medications are used for the right reasons with the right patients in the right dosages. She offered a supporting case. A 90-year-old woman was on a small dose of antipsychotics. She was doing well on the medication, but then it was discontinued as part of the effort to reduce facility-wide antipsychotic use. She stopped eating, became aggressive, and spent her last year in a geropsychiatric unit.

“I'm sure that many patients have been taken off of antipsychotics successfully, and they are not appropriate or necessary for every patient,” Dr. Nash said, but “those who need these medications should be able to get them.” She shared another story about an elderly resident in an assisted living facility who

was taken off chlorpromazine despite his objections. The decision was made without consulting his family or other practitioners. He became paranoid and delusional, and ultimately ended up in the hospital.

“I put him back on the drug that had helped him in the past. He was

“Quality metrics for antipsychotics involves a blanket rate of use and doesn't address the fact that these drugs are needed for illnesses such as bipolar and some recurrent major depressions.”

no longer delusional, but he refused to go back to the assisted living facility,” Dr. Nash said. “He didn't forget what happened there.”

Dr. Nash said antipsychotics shouldn't be used for sleep, wandering, or behavioral problems that can be managed without medications. “We want people

off antipsychotics who don't need them,” she said, but she acknowledged their necessity as a treatment option for people who are paranoid, hallucinating, or delusional.

It is essential to have very detailed and specific diagnostic criteria in resident charts, as well as documentation of conversations with patients and families. In some states, said Dr. Smith, “State survey agencies have become aware of certain prescribers who have started to add a diagnosis of schizophrenia to residents' charts without proper diagnostic criteria in order to justify antipsychotic use and get around the regulations. This is considered to be both fraudulent and unethical.”

More than ever, PA/LTC facilities are juggling a wide range of challenges, and many are adding chronic mental illness management to this list. With strong teams, guidance from experienced practitioners, and the right education and training, they can effectively tackle this challenge as they have others in the past. 

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EDITOR'S NOTE

This article makes some great points, and the new regulations have a lot of specific language around behavioral health services in the skilled nursing facility setting — so it behooves our members and their institutions to ensure appropriate training in behavioral health and serious mental illness. Personally, although I am very sympathetic to the plight of the seriously mentally ill population — especially those with chronic medical problems and homelessness — I have reservations about opening up our facilities to them indiscriminately. I have seen too many cases where a nursing center agrees in good faith to admit one of these residents, then comes to find out that the person is actively using illicit drugs, resistant and non-adherent to care recommendations, and verbally abusive (or worse) to other residents and staff. I feel we owe it to our vulnerable elder population to protect them from living in a milieu with others who may be frightening and literally dangerous to them. Once these individuals are admitted, it is virtually impossible to evict them — and getting more impossible all the time. I wish I had a simple answer to accommodate the needs of this unique population, but I don't. Perhaps in time some creative solutions will emerge, but in the meantime, we should be cautious, and limit admissions to those residents with needs we can meet — and who will not threaten the safety, well-being, and peace of mind of our ‘usual’ resident population.

—Karl Steinberg, MD, CMD, HMDC
Editor in Chief



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