Meeting the Emotional and Behavioral Needs of Younger Residents in Long-Term Care
By Lisa Lind, PhD

The National Center for Health Statistics reports that 16.5% of long-term care residents are younger than 65 (Vital Health Stat 3 2016;38:xii,1–105). However, we know that some LTC facilities tend to have higher concentrations of younger adults, and it is not uncommon to encounter individuals in their 20s. Younger adults who reside in LTC settings often fall into one of the following groups:

- Individuals with developmental disabilities or autism who could no longer have their medical needs met in another environment.
- People who’ve had a significant medical event such as an motor vehicle accident (MVA), stroke, traumatic brain injury, or spinal cord injury that resulted in physical impairment such as hemiplegia or quadriplegia.
- Individuals with progressive and debilitating medical illness or neurological disorders, such as multiple sclerosis, amyotrophic lateral sclerosis, or Huntington’s disease.
- People whose substance use, severe obesity, or prior criminal activity has resulted in negative consequences that require care in a skilled nursing facility.
- Individuals with chronic mental illness who are unable to care for themselves in the community due to impaired judgment or cognition.

Although not every younger LTC resident exhibits a mental health or behavioral condition, there are often common emotional and behavioral challenges that emerge as a result of their medical condition. Commonly observed issues include:

- Verbal and physical altercations with staff and other residents
- Verbal abuse of staff or others
- Noncompliance with facility rules, medication regimens, or self-care
- Substance misuse
- Calling police for nonemergent issues
- Exit seeking and/or leaving the facility
- Sexual activity
- Inappropriate social interactions with residents or staff
- Manipulative behavior
- Calling the State Ombudsman to complain about personal care and/or rights violations
- Sleep patterns not consistent with the LTC milieu (e.g., sleeping all day and staying up throughout the night)

Although detailed behavioral interventions go beyond the scope of this introductory article, here are some basic suggestions to meet the needs of younger adults in LTC settings and to decrease the potential for behavioral issues.

1. Make a referral to your mental health provider. Soon after the resident is admitted to your facility make this referral, especially if the resident will be remaining for LTC. For any young adult, residing in a long-term setting at a young age can be a difficult adjustment, and it will be important to have professional support in place. These residents are likely dealing with symptoms of a chronic mental illness and significant medical issues that have impacted their psychosocial functioning. There are often behavioral issues as well, such as substance misuse, impulsive behavior, or anger management that will benefit from professional behavioral health treatment.

2. Screen for trauma. Many of the reasons for a younger resident being placed in LTC have their origins in a traumatic event (such as an MVA or stroke). Facilities need to employ a trauma-informed care approach in order to prevent retraumatization.

3. Provide clearly stated policies regarding resident behaviors. Make clear the policies on substance use, aggression, elopement, and sexual activity; also make clear that they will be enforced, have the resident sign an acknowledgment that they have received the information, and give the resident a copy they can refer to.

4. Provide staff with appropriate education and training. Training should focus on the following topics:
   - Identifying and documenting psychiatric signs and symptoms.
   - Handling aggressive behavior, such as de-escalation strategies and identifying antecedents to behaviors.
   - Setting and maintaining boundaries with residents to avoid role confusion and help staff respond to manipulative behaviors.
   - Clarifying facility rules on issues such as substance use, sexual intimacy between residents, and the appropriate documentation and reporting requirements with respect to violations.
   - Instilling awareness of how not to inadvertently reinforce maladaptive behaviors.
   - Training staff in stress management.

5. In facilities with a high prevalence of psychiatric needs, hire staff who

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Mrs. R is a 47-year-old White woman who moved into the long-term care facility in 2018 when she needed more assistance than could be provided in her adult-care home. Her medical history is long and complicated: rheumatoid arthritis with multiple joint replacements, seizure disorder, right hemiparesis due to cerebrovascular accident, coronary artery disease with iron deficiency anemia, and rheumatic heart disease with aortic and mitral valve replacements.

Her medications include Zofran at 4 mg every 8 hours as needed; aspirin at 81 mg daily; vitamin D at 1,000 units daily; gabapentin at 200 mg at night; ferrous sulfate at 325 mg daily; enentercept solution autoinjector at 50 mg once weekly; and Coumadin at 4 mg daily. She also receives milk of magnesia, a Fleet enema, and Tylenol as needed. Mrs. R has full decision-making capacity and is involved with all aspects of her care. She is independent with her electric wheelchair.

She had tested positive for COVID-19 on rapid antigen testing — not once but also on a repeat test — on a wing of the 19 unit would expose her to even more risk while she awaits the result of her PCR test. Mrs. R was indeed infected at some point. With her presumed immune suppression, things are even less clear. It is imperative to isolate her for a period with full precautions — preferentially keeping her in a single-occupancy room in her own unit so she can return to her usual long-term care room if her PCR result is negative. Being in the COVID-19 unit would expose her to even more risk while she awaits the result of her PCR testing, and she would be committed to at least 7 to 14 days of quarantine before being able to return.

Mrs. R has a high probability of rapid decline given her complicated health status. With her fever, reduced oxygen saturation, and COVID-19 Isolation, her LTC room will need to be converted to a private room with full precautions — preferentially keeping her in a single-occupancy room in her own unit so she can return to her usual long-term care room if her confirmatory PCR test returns negative. Being in the COVID-19 unit would expose her to even more risk while she awaits the result of her PCR testing, and she would be committed to at least 7 to 14 days of quarantine before being able to return.

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Being isolated can be daunting and discouraging. The staff can help support Mrs. R by ensuring that she has items from her LTC room such as electronic devices and supplies (such as hobby materials) that she could use to occupy her time. These items can be dispensed when she returns to her own room. The activity staff can provide daily visits and assist with facilitating video visits (such as FaceTime calls) with her family and friends, if needed. Consider using the free resources from the TimeSlips website, such as the Beautiful Questions, to stimulate creativity and conversation (www.timeslips.org/resources).

Perhaps Mrs. R would be interested in paper games such as word finds, Sudoku, and crossword puzzles. Given her arthritis, the activity staff can provide her with adaptive equipment (grips for writing utensils and a stylus if she uses one for her electronic devices) to help facilitate her independence and enjoyment with her daily leisure pursuits.

To facilitate communication that follows COVID-19 protocols, the staff can use door hangers that convey her requests. Even in isolation, she can still enjoy special snacks like root beer floats or other treats when special days or events are honored.

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INTERDISCIPLINARY TEAM CASE STUDIES

By Barbara Resnick, PhD, CRNP, and Paige Hector, LMSW

A Younger Adult With Rheumatoid Arthritis and COVID-19 Isolation

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have psychiatric training or background (nurses, social workers, etc.). Staff who have the appropriate experience are more comfortable working with residents who have high psychiatric needs.

6. Tap into the strengths of the younger resident. Identify ways in which he or she may be helpful to the other residents. For example, many older residents whose family members are not active in their life may enjoy interacting with someone of the age of their own children. Pairing younger and older adults as roommates can be mutually beneficial, and it may decrease potential behavioral issues (which can occur when roommates have similar emotional or behavioral functioning).

7. Offer activities that target younger adults. Although some younger adults enjoy the traditionally offered activities such as bingo, many do not. Identifying age-appropriate opportunities for positive interactions can help, such as incorporating technology into activities.

8. Provide a list of available resources to the resident that are specific to his or her individual needs. Residents’ sense of perceived social disconnection can be decreased by access to social support with individuals of similar life experiences. For example, if the resident has multiple sclerosis, ensuring access to an online support group may be beneficial. If the resident is in recovery from alcohol use disorder, providing information on local Alcoholics Anonymous meetings could help (or arranging for meetings at the facility if a large number of residents would benefit).

Refer to The Younger Adults in the Long-Term Care Setting (R.L. Ferrini et al., 2013: https://bit.ly/3s7bUM), a tool kit from AMDA – The Society for Post-Acute and Long-Term Care Medicine, for more information on best practices when dealing with younger adults.

The tool kit includes guidance on:

- Identifying individual perspectives that inform needs and wants.
- Facilitating appropriate relationships between residents and staff.
- Anticipating cognitive problems.
- Making facility policies and behavioral management practical.
- Preparing staff to care for younger residents.
- Advocating for the value of a long-term perspective.

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