Dear Dr. Steve: When residents have behavioral disturbances that result in violent actions, one of my nursing homes sends the patient to the emergency room. In the emergency room, the ER doctors often do not see any acute need for psychiatric stabilization or admission, and I want to send the patient back with clearance from the ER doctor. The nursing home, however, insists that there be clearance specifically from a psychiatrist. Is such clearance necessary? How should my facility handle patients with behavioral and psychiatric issues?

Dr. Steve responds: For over 25 years, as a clinician and medical director, I have been extensively involved in helping facilities across the country diagnose and manage thousands of nursing home residents and patients with behavior and psychiatric issues (BPIs), covering many of the major DSM-5 diagnostic categories (Diagnostic and Statistical Manual of Mental Disorders, 5th ed., American Psychiatric Association, 2013). Patients with significant BPIs challenge medical practitioners and facilities in every setting. Those with a psychiatric history and/or certain diagnoses such as schizophrenia and bipolar disorder are especially challenging. Unlike assisted living, which can more readily reject admissions with tough behavioral issues, many nursing homes take people with significantly impaired or problematic behavior and major underlying psychiatric disorders. 

Even under the best circumstances, managing the residents with more complex behavior issues can be exhausting and frustrating for nursing home staff. Although some individuals with BPIs are minimally disruptive and readily manageable, many others are relentlessly anxious, manipulative, obsessive, and demanding, if not repeatedly dangerous to themselves and others. It is not unusual for some nursing home residents to kick, punch, or bite staff, throw objects, pull plugging out of the wall, smash computers onto the floor, overturn desks and tables, and insult, curse, intimidate, and threaten staff.

There is a huge amount of advice out there about assessing and managing BPIs, including from reputable professional organizations and quality improvement organizations; the Centers for Medicare & Medicaid Services also offers well-intended but often limited interpretive guidance and training. Although such general information may work for straightforward situations (such as uncomplicated depression), it must always be tailored to the specific clinical situation. For example, depression may be part of the cycle of a patient with bipolar disorder, complicated by psychosis, or may be precipitated by excessive doses of antiepileptic medication that is being used to treat pain, a seizure disorder, or, inappropriately, to treat aggression in someone with dementia.

Here, then, are some tips based on experience for handling all behavior and psychiatric issues, including (but not limited to) serious mental illness.

Describe Behavior, Mood, Cognition, and Function in Detail

The first step is to set aside the diagnosis—not necessarily, but initially. All psychiatric symptoms and behavior are nonspecific (i.e., they do not automatically represent a specific condition). It is vital to avoid premature assumptions and instead identify the precise issues. Details (including a chronological story) of the individual’s mood, cognition, and behavior, along with related issues such as appearance, thought content, attention, and level of consciousness are always important, particularly to identify how multiple diagnoses might be at play (e.g., dementia and another psychiatric disorder). Details are also needed to determine whether the behavior is a problem, to identify its possible causes, and to identify whether specific medications are potentially indicated or still needed. Deciding whether to taper or stop any existing medications—including, but not limited to, antipsychotics—also requires a thorough history and assessment.

No matter the situation, expect the staff to describe an individual’s mood, cognition, function, and behavior in detail, including when it starts or escalates, its intensity or severity, how often it occurs, how long it continues (both in the short-term and over time), and its consequences (including impact on a patient’s functioning and quality of life and on other residents and staff). Single words (such as “agitated” or “combative”) are too general to be helpful, and they often lead to erroneous conclusions and misguided treatment. The staff should also use a consistent vocabulary.

Psychiatric symptoms (psychotic delusions, hallucinations, and paranoia) must be described precisely and distinguished from nonpsychotic suspiciousness and bizarre thinking, which are quite common even among individuals who do not have a psychiatric history. For example, I remember a patient with long-standing schizophrenia whose delusion was that a fungus inhabited her abdomen and was the cause of all her problems. She would complain about it relentlessly and demand that something be done about it. Yet her obsessions did not result in disruptive or destructive behavior, and they had a moderate impact on her function and quality of life. She remained reasonably stable on her low-dose antipsychotic medication for schizophrenia, which she took intermittently.

Practitioners play a crucial role in addressing behaviors

Some medical practitioners are adept at evaluating and helping manage basic BPIs. Many, however, fear and avoid addressing these symptoms. Instead, they order—or allow the staff to order—psychiatric consultations, and they let the psychiatric consultant manage the entire situation. However, medical practitioners have an essential role to play. For example, delirium due to a medical condition that presents as changes in function, behavior, attention, or level of consciousness requires prompt medical and nursing evaluation and intervention.

Medications in just about any category can also cause or exacerbate BPIs. For example, as discussed in the DSM-5 Handbook of Differential Diagnosis (APA, 2014) by Michael B. First, MD, the first step in psychiatric diagnosis is always to rule out and address medical conditions and substances (i.e., both prescribed medications and missed or abused medications and substances such as alcohol and drugs of abuse) before concluding that there is a psychiatric disorder such as mental illness.

Expect your staff and practitioners to review every patient’s current medication regimen for medications (e.g., opioids and anti-Parkinson medications) that can affect mental status or behavior.

Capsule psychiatric consultants can be helpful and are sometimes essential (e.g., in selecting and managing multiple medications in a patient with complicated or refractory schizophrenia or bipolar disorder), but there are many challenges in relying on them (see my discussion of OBRA regulations in Caring for the Ages 2021;22[1]:8–9). Medical practitioners must remain involved and identify whether they are getting the advice they need, especially when patients continue to cause major problems despite treatment.

Collaboration between staff and a medical practitioner is also needed to identify how problematic a behavior is, and whether it can be managed more by nonpharmacological interventions.

Clarify and verify diagnoses

Ultimately, it is important to clarify and verify psychiatric diagnoses. Many are incorrect and often are mutually incompatible or contradictory. I have seen many patients with personality disorders, substance use disorders, developmental disabilities, and other issues inappropriately labeled as mentally ill and given significant doses of unwarranted medications such as antiepileptics and antipsychotics. It is not uncommon to have each symptom given its own diagnosis when a single diagnosis can adequately explain all the symptoms.

Verify the diagnosis by matching a patient’s actual mood, behavior, and cognition to published criteria for that diagnosis. All diagnoses have published criteria. For example, typing “schizophrenia diagnostic criteria” into Google gives quick access to reliable symptom information: seeing, hearing, feeling, or smelling things that are not real (hallucinations), having bizarre beliefs (delusions), or experiencing flights of ideas and disorganized thinking and speaking. The condition occurs in approximately 0.5% of the population and only rarely starts in later life. The diagnosis depends on a history of symptoms over time, and cannot generally be made just based on one or two symptoms such as having delusions or saying bizarre things. The aforementioned DSM-5 Handbook of Differential Diagnosis has extensive and useful diagnosis algorithms.

Identify and document a clear rationale for all interventions

Thinking through the basis for conclusions helps improve the chances of making good interventions and reduces the risk of using medications inappropriately or giving ineffective or potentially harmful treatment. A documented and clear rationale helps the staff and practitioner create and implement an individualized plan. Expect your staff and practitioners to document why they chose specific interventions and how those interventions relate to identified or suspected causes of a patient’s BPIs. If management of a BPI requires a medication, the physician (or the staff, based on discussion with the physician) should document the explicit rationale for the medication (not just a diagnosis).

As noted, psychiatric consultation may or may not be helpful. A capable psychiatric consultant should be able to help the staff and practitioners by explaining and documenting precisely what is being treated and exactly why the chosen approaches are warranted. For example, bipolar disorder is primarily a mood disorder, but it is sometimes complicated

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by psychotic features. The diagnosis is based on a history of at least one episode of mania or hypomania; bipolar depression is not the same as a major depressive disorder, and mania can be caused by various medications, necessitating a review of all of the existing medication regimen before adding more medications. If someone with bipolar disorder is increasingly manic and is being treated with an antidepressant, it is generally appropriate to first reduce the antidepressant dose instead of adding more antimanic medication.

Because of their risks for causing adverse reactions and other complications, psychopharmacological medications should be used for specific indications. Short-term therapeutic trials can show whether a medication may be helpful. When there is no meaningful improvement despite increasing doses of a specific medication or multiple trials of medication in a category (such as antidepressants or antimanic medication), then the entire situation should be reconsidered. This includes diagnostic accuracy and appropriateness of treatment selection.

Ultimately, approaches to patients with mental illness and other psychiatric syndromes must be prudent, detailed, and systematic. Except in extreme situations, reacting with fear and panic (e.g., by calling the police or repeatedly sending someone to the emergency department) may be understandable but is mostly a fruitless and irresponsible way to handle these individuals.

Nursing home administrators and owners must know whether their staff and practitioners are capable of managing the patients that their admissions staff accept. Admissions offices and company policies should be aware that one “psychiatric” patient is not the same as the next one. In preadmission screening, the diagnosis alone is insufficient to enable adequate preparation to take and manage a patient. A facility that lacks a systematic, clinically valid approach to managing behavior and psychiatric issues would most likely be better off avoiding taking such admissions.

Our duty is to act professionally, use appropriate terminology, follow the care process, know what we are doing and why, and influence the actions of less skilled clinicians and staff. Don’t assume anything, have an organized approach to getting detailed information, and do not overly obsess about treatment to the detriment of thinking through the underlying issues.

F-tags developed to assess the adequacy of mental health supports and services in nursing homes — have had any impact is also a question “not yet addressed in the academic literature,” he said. “In my own musings of CMS data, these citations are not being given out in large numbers,” he said. “Whether that means facilities are actually providing adequate mental health care, or whether state surveyors aren’t necessarily looking … is not yet known.”

Overall, Dr. Jester noted, research has focused on how the nursing homes themselves have been affected by higher numbers of residents with SMIs. “Very few researchers are going into the facilities and trying to understand the residents’ experience,” he said. “I believe that’s what needs to happen going forward.”

As for assisted living communities, the experience of people with SMI, most of whom are dually eligible for Medicare and Medicaid, is also worth looking into. A study published this year that analyzed samples of Medicare beneficiaries found that the prevalence of SMI in assisted living increased by 54% from 2007–2017, rising from 7.4% to 11.4% (Am J Geriatr Psychiatry 2021;29:434–444). The rate of increase was faster than that in the surrounding community but slower than that in nursing homes.

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