Managing Serious Mental Illness: Team Training, Antipsychotic Therapy, and Research Trends

By Christine Kilgore

At Harmony Pointe Nursing Center in Lakewood, CO, where about 30% of residents have a chronic, serious mental illness (SMI) such as schizophrenia or bipolar disorder, the staff receive training about mental illnesses and how to manage behaviors. Psychiatrists and other experts contracted by the facility’s parent company and available through local community alliances help manage treatments and other needs.

But equally important, say Frances Holliday, BSN, RN, the facility’s administrator, and Jamie Francuski, BSW, resident services coordinator, is the “in-the-moment” education that occurs with staff to discuss particular behaviors and unmet needs, and an overall approach at the center that promotes open-mindedness and individualized care.

“When I was a nurse I was terrified of behavioral health. I didn’t understand the behaviors, the disease process — any of that,” Ms. Holliday told Caring.

“Then when I started working with people with dementia and realizing that some of them had primary behavioral or mental health diagnoses, it made me realize how much I need to focus on the person and not the disease process.”

Not all individuals with SMI are admitted at Harmony Point; those who are not stable on medications, for instance, or who have physically violent behaviors or who frequently slip away from buildings tend not to be a good fit. But in caring for those who are admitted, being “open-minded and thinking outside the box has helped us to be successful,” Ms. Holliday said.

Key Guidelines for Gradual Dosage Reductions of Psychotropic Medications

By Rick Foley, PharmD, CPh, FASCP, BCGP

Gradual dosage reductions (GDRs) of psychotropic medications are required by federal guidelines in skilled nursing facilities. Equally important is the fact that GDRs are a crucial cornerstone of good clinical and pharmaceutical care. Thorough evaluation of each medication prescribed to residents should be made on a routine basis, with detailed documentation justifying the continued utilization of any medication. This process is especially crucial when medications are being employed outside the typical standards of care. I am often asked, “How does a facility implement a successful graduation dose reduction program?”

Who is a Candidate for GDR of Psychotropic Medication?

Many nursing home residents routinely take multiple medications, many of which have unwanted side effects. In the broadest sense, any resident taking any medication should be considered a candidate for GDR.

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“We work [continuously] to destigmatize mental illness,” said Ms. Francuski. “We’re so afraid of behaviors, of people being different, that we don’t ask our- selves, is it really a big deal if someone acts this way, if they can do it safely?”

A Troubling Trend Overall

Estimates of the prevalence of SMI in nursing homes vary at least partly because there is no single standard definition of SMI. LTCFocus (ltcfocus.org), a collection of data produced by the Shaping Long-Term Care in America Project at the Brown University Center for Gerontology and Healthcare Research, shows that in 2019 the by-state preva- lence of nursing home residents with schizophrenia or bipolar illness ranged from approximately 5% to 21%. In 2000, the range had been 3% to 13%.

Other researchers use the broader Centers for Medicare & Medicaid Services definition, which captures ill- nesses such as anxiety disorders and post-traumatic stress disorder. One recently published study used Minimum Data Set (MDS)-generated data from the national Certification and Survey Provider Enhanced Reports (CASPER) to examine the distribution of SMI in nursing homes; it found that most facilities reported a prevalence of SMI of 20% to 40% (Gerontologist 2020;60:1312-1321).

It’s unclear how much of this reported prevalence may reflect fabricated diagnos- es of schizophrenia used to justify the use of antipsychotics as opposed to increased diagnoses of mental illness or increased admittance patterns, said Dylan J. Jester, PhD, MPH, a postdoctoral fellow at the Stein Institute of Research on Aging at the University of California—San Diego School of Medicine, and lead author of this study.

Estimates aside, ever since the clos- ure of state psychiatric hospitals and deinstitutionalization of those with SMI decades ago, nursing homes have increas- ingly cared for the chronically mentally ill. “Many people with significant and persistent mental illness are homeless, in jail, or in SNFs [skilled nursing facilities],” said Richard Juman, PsyD, director of behavioral health policy and regulation with TeamHealth, a provider of nursing home care. “Skilled nursing may well be the largest provider of ongo- ing care for this population.”

Psychiatrist Lee Watson, MD, MPH, who advises facilities caring for people with SMI, said many of these residents have been affected by poverty and home- lessness and often have a sentinel event such as a stroke or accident that renders them incapable of caring for themselves. Some are admitted directly from the surrounding community, but many are admitted after prolonged hospitaliza- tions, sometimes from the post-acute care setting, Dr. Watson said.

It’s a troubling trend, considering that SNFs — their setup, staff, culture, and funding — were not designed to care for individuals with SMI, both she and Dr. Juman pointed out. The two co-chairs of the Behavioral and Mental Health Advisory Council of AMDA – The Society for Post-Acute and Long-Term Care Medicine.

“There’s broad consensus that this model is not working and sincere hope that nursing home reform that may occur post-COVID may have some innovative [behavioral and mental health] models,” Dr. Watson said. “There need to be payer incentives to do the right thing.”

Alliances and Training

A lack of staff training and access to mental health care expertise are among the concerns. Harmony Pointe is for- tunate, Ms. Francuski said, in that its parent company, Vivage, has a behavioral health unit. “It didn’t function well,” she said. But overall “we must take advantage of the opportunities we have here. I wish we had more staff with specific training [for people who do live here],” Ms. Francuski said.

Antipsychotic Therapy, Diagnostic Clarity

Life-long antipsychotic therapy for individuals with schizophrenia, bipolar disorder, and other chronic psychotic illnesses is the standard of care, said Dr. Jester. Yet there are scenarios in which gradual dose reduction (GDR) of antipsychotics and other treatments can or should be considered, including long-standing stability, experiences with side effects, or concerns about potential drug interactions with agents needed for new medical problems.

“Meetings to review the utility of psy- chotropic agents are a really great opportunity to say, this 90-year-old resident has been on the same dose of Haldol for 45 years and has been completely stable. Maybe we should consider lowering the dose,” Dr. Watson said.

On the other hand, both age and the development of dementia can create new diagnoses of SMI and newly problematic side effects. “Certain medications do have more potential harm as you age, and additively, as you have dementia,” she said. “We do think that a brain with dementia is a more vulnerable brain.”

Moreover, “people can get to a point where their dementia eclipses the chronic instability and more problematic side effects.” At which time GDR is advisable, she added. “But sometimes they don’t,” and need to continue anti-psychotic therapy.

GDR is less valuable, and often inap- propriate, in residents with SMI who are younger and “without a lot of other medical problems,” Dr. Watson empha- sized. “There’s fairly good evidence to suggest that [in these cases] the med- ications and doses that got them well are the doses we should leave them on.”

Diagnostic clarity upon admission, and particularly after hospitalization, is critical, she noted. It’s not com- mon for people to be admitted with new diagnoses of SMI and newly introduced psychotropic medications. “In some cases,” Dr. Watson said, she’ll “take people off all their medications and start over” while confirming prior diagnoses.

Positive Experiences, a Sense of Belonging

Appropriate medical treatment to minimize symptoms of psychosis, anxiety, or mood instability is a key part of opti- mizing the quality of life for residents with SMI.

But just as important are interactions and activities that create positive emo- tional experiences, a feeling of belonging, insight into one’s conditions and treat- ments, and feelings of self-acceptance and self-esteem, said Lisa Lind, PhD, a psychologist who works directly with long-term care (LTC) residents and a leader with Deer Oaks, a LTC-focused behavioral health care provider.

“The most important underlying fac- tor is that staff create a safe environ- ment where residents feel valued and respected,” said Dr. Lind, also president of Psychologists in Long-Term Care (PLTC), and a member of the Society’s Behavioral and Mental Health Advisory Council.

“It’s important for residents to have access to mental health providers, but it’s also imperative that the staff who interact with them 24 hours a day have appropriate knowledge about [their] conditions, so their actions and com- ments don’t unintentionally stigmatize residents or lead to alienation,” she said.

It’s imperative too that residents have peer support. They need interactions and activities “with peers who have similar life experiences or who are known to be able to help bridge the space of connectedness,” Dr. Lind said.

Attention to trauma-informed care also benefits all residents and staff, but has special value for residents with SMI, a high prevalence of whom have a history of significant trauma, Dr. Lind noted. Structure and activities are critical for a facility’s success with SMI, said Dr. Juman. “Particularly for people with psychotic disorders, boredom is a fer- tile environment for hallucinations and delusions and the symptoms of their illness to emerge,” he said.

Activities planning at Harmony Pointe is in many ways a whole-building affair with input from residents, staff, and mental health providers. “We tailor activities based on what the residents’ interests are, along with what we think can help them,” said Ms. Francuski. Residents with SMI have participated in an antibullying committee, for instance, but “you also just want to have fun,” she said. “Our residents [with SMI] are very vocal about what they want to do and see.”

Researching Quality

In the research world, meanwhile, ques- tions abound about the quality of care provided to LTC residents with SMI. Dr. Jester’s study of SMI in nursing homes categorized facilities into quartiles based on the proportion of residents with SMI and found that “high-SMI” facilities (≥44.62% of residents with SMI) were more likely to have lower staffing levels and lower scores on all Nursing Home Compare ratings. But most nursing home residents with SMI are covered by Medicaid, and Medicaid itself influences nursing home quality, he said.

“What is the role of Medicaid? It is really Medicaid driving lower staffing levels and lower quality star ratings, or is there some cedence to the idea that having a large portion of residents with SMI is difficult for the staff and the facil- ity?” said Dr. Jester. Whether the 2017 CMS regulations — and the deficiency

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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 behavioral 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.

Dr. Levenson has spent 42 years working as a PALTC physician and medical director in Maryland.

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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.

Christine Kilgore is a freelance writer based in Falls Church, VA.