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## Many Needs But Few Psychiatric Services for Seniors in Long-Term Care

by William Kanapaux

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Research suggests that more than three-quarters of nursing-home residents exhibit mental health problems, including dementias such as Alzheimer's disease (AD). Yet psychiatric care in long-term care facilities is lacking. Low reimbursement rates, staffing issues and lack of attention by the facilities themselves have contributed to the problem.

Moving to an assisted-living facility or nursing home can be a distressing and disruptive experience. Patients may suffer from anxiety, depression and reactive adjustment disorders. They may experience an exacerbation of physical problems, sleep disturbances and appetite problems, all based on relocation stress.

That is the case for the average patient, Elliott M. Stein, M.D., told *Psychiatric Times*. Stein is a geriatric psychiatrist in private practice. People with cognitive disorders such as AD and dementia have additional stress when they are relocated because they have more difficulty adapting. They may have more trouble understanding what is happening to them or learning their way around. They may become more disoriented because they are in a strange location.

Medicare reimbursement inhibits psychiatrists from providing services to patients in assisted-living facilities and nursing homes, Stein said. As is the case with other outpatient settings, Medicare has a discriminatory restriction on providing services to nursing-home patients with mental illnesses. The program reimburses psychotherapy and other mental health care services at 50% of the allowed amount,

compared with 80% of the allowed amount for physical illnesses. Treatments for AD and dementia are an exception to this, but only for medication management, which is reimbursed at 80%.

These restrictions on reimbursement are a limiting factor in bringing appropriate psychiatric care into long-term care settings, said Stein, former president of the American Association for Geriatric Psychiatry and the association's Clinician of the Year for 2003.

Furthermore, the rates that Medicare allows for psychiatric care in these facilities are set at a prohibitively low level compared with reimbursement rates for providing the same services in a psychiatrist's office, he said. This also erodes access to adequate care, since residents in these facilities are often unable or unwilling to make office visits.

### **Staffing Levels and Training Need To Be Addressed**

One of the concerns of the National Citizens' Coalition for Nursing Home Reform (NCCNHR) is that nursing homes be equipped to deal with the mental health care needs of their residents. Staff training for managing behaviors associated with mental health care needs is one concern, but so are staff levels in general. If staff levels are low, supervision of patients with special needs can suffer.

According to NCCNHR Executive Director Alice H. Hedt, congressional legislation that would address staffing levels in nursing homes stood little chance of passing this year, and most laws addressing those concerns are likely to be on a state-by-state basis.

Currently, about 92% of facilities are not staffed at a level to provide adequate physical and medical care, Hedt told *PT*. "Then, when you compound it with complex mental health needs, you add on the issue of how well equipped the staff is in terms of training."

Nursing-home patients with AD and other dementias have different needs than do other patients in terms of supervision, Julie Meashey, ombudsman specialist at NCCNHR, told *PT*.

Patients in advanced stages of the disease sometimes need changes within their environment to make it safe. Some facilities have specialized units with higher staff levels and specialized activities, but other facilities integrate the patients within the larger population.

Patients who wander or are unsteady on their feet, or who are bed-bound, require higher levels of staffing, Meashey said.

Staff members need to make sure that patients do not leave the facility or wander into other patients' rooms. If a patient needs to walk, then the staff must find a way to accommodate that.

Currently, no federal standards exist for staffing levels, Meashey explained. Minimum direct-care staffing standards developed by NCCNHR in 1998 have yet to be adopted by individual states, although Maine is the closest to meeting these standards. The standards, which were developed in consultation with long-term care experts over a number of years, call for nursing-home residents to receive at least 4.13 hours of direct nursing care each day.

### **Need for Services To Improve Cognition and Quality of Life**

A number of these patients need more than a medication check, Stein said, and psychiatrists need to work with facility staff and the patient's family as well. He added, "Patients who have a mild cognitive decline may still benefit significantly from psychotherapeutic interventions."

Alzheimer's disease is undoubtedly a mental illness, Stein said. It affects multiple systems, such as the neurons of the brain and the body's ability to perform basic functions such as walking, eating and sleeping. "Its primary symptoms are symptoms of memory, behavior and emotion."

A study appearing in the July/August issue of the *American Journal of Geriatric Psychiatry* found that patients who are mildly impaired by AD can improve at face-name associations, orientation, cognitive-processing speed and specific tasks, such as making change and paying bills.

Using a new cognitive-rehabilitation program that involved two 45-minute sessions a week for 12 weeks, researcher David A. Loewenstein, Ph.D., concluded that a systematic program could result in maintained improvement in performing specific tasks for mildly impaired patients.

The study found that patients with AD who participated in the cognitive-rehabilitation program for three to four months experienced a 170% improvement, on average, in the ability to recall faces and names compared with patients who did not receive the intervention. The study also found a 71% improvement in the ability of patients to make correct change for a purchase. According to the study, the improvements were still evident three months after the training ended.

A second study, published in the June issue of *Neuron*, found that older people with early-stage AD still retained

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functioning levels of implicit memory that were similar to levels for young adults and older adults without AD.

"Taken together, these studies introduce the exciting notion that older people who are in the early stages of AD can be taught techniques to help stay engaged in everyday life," said Neil Buckholtz, Ph.D., head of the Dementias of Aging Branch in the National Institute on Aging's neurosciences program.

### **Care for Institutionalized Patients With SMI**

Dementia isn't the only mental health problem that seniors in long-term care facilities face. Older people have a high incidence of depression, anxiety and other emotional disorders. And although doctors are recognizing these disorders more frequently now than in the past, they are still largely underdiagnosed and undertreated, Stein said. Many patients with these disorders end up in long-term care facilities.

Also, people who have had a lifelong serious mental illness (SMI) frequently end up in long-term care. At one time, such patients would have spent their final years in a state hospital, but no longer.

According to a study appearing in the December 2003 issue of the *Journal of the American Geriatric Society*, 89% of older people with SMI who are institutionalized reside in nursing homes. The researchers of the study reported:

Older persons with SMI who reside in nursing homes have greater functional impairment in self-care skills and community living skills, worse general health, more-severe negative (deficit) psychotic symptoms and cognitive impairment, more aggressive behaviors, and less social support than those who live in the community.

"In addition, several studies suggest that older adults with SMI are at a substantially greater risk of institutionalization than other groups of older persons," the researchers continued.

Preparedness to handle patients with SMI varies, Stein said. Overall, it appears that long-term care facilities are vastly underserved. This results from an inadequate number of psychiatrists and psychologists treating these patients and through a lack of staff awareness and training at the facilities themselves.

Some facilities train their staff well and have psychiatrists on staff to provide services, Stein said. "When it is done well and properly, it can be of great benefit, both to the facility and to

the patients within the facility. But getting that staff trained and getting [psychiatrists] to come see people in a facility is not done on a systematic basis."

Some facilities do not see a need for psychiatrists, except when told by state regulators to have one check on a patient's medications, Stein explained. Ultimately, it depends on the availability of willing geriatric psychiatrists and on the willingness of facilities to have them treating their patients.

A 2001 report by the Office of Inspector General at the U.S. Department of Health and Human Services found little evidence of compliance with required screenings for mental illness in nursing-home patients, which are supposed to be conducted through the Preadmission Screening and Resident Review (PASRR) system. The report found that only 47% of sampled residents had a Level I PASRR screen in their nursing-home records. And only 41% had any evidence of a Level II PASRR, which screens for SMIs.

Level II PASRR reviews, which are supposed to occur with any significant change in a resident's mental health condition, rarely occurred, the report said. Of the cases reviewed, only 29% of patients who had an initial Level II PASRR screening also had a review, and all those were conducted before the annual reassessment requirement was repealed in 1996.

### **Challenges of Poorly Trained Staff**

One of the difficulties that nursing homes face is making sure that caregivers recognize the types of behaviors that could be addressed by mental health care practitioners, Meashey said. Staff training is sometimes lacking in that area, especially as it involves patients who have behavioral symptoms.

Staff members who are poorly trained may not recognize that certain behaviors are communication attempts by the patient. This can lead to abuse or neglect if the caregiver loses patience with the individual. A patient may hit a staff member as a way of communicating that they do not want to do something. This can cause the staff member to strike back in self-defense or out of frustration.

A patient with AD or dementia may need assistance with bathing or going to the bathroom, which brings up issues of dignity and privacy, Meashey said. Depending on the staff member's approach, a patient who feels vulnerable may become violent or defensive. However, a staff member who is trained to recognize violent or defensive behavior as fear or concern may use a different strategy to prevent the situation from escalating.

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Behavior changes may also indicate that a disease is progressing or that the medication mix is a problem. A patient with dementia might also act out to signal pain, Meashey said. It could be an indication of a new condition, such as a sprained ankle, or even a broken hip, if the patient fell without being noticed. Staff members need to be trained to consider pain. "These are the things that if somebody's trained to think about, they might be assessing for," she said.

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