

David K. Conn · Nathan Herrmann · Alanna Kaye  
Dmytro Rewilak · Barbara Schogt (Editors)

# Practical Psychiatry in the Long-Term Care Home

A Handbook  
for Staff



Third Revised  
& Expanded Edition

HOGREFE



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# Foreword

Ira R. Katz

Why should there be a “Handbook for Staff” on practical psychiatry in the long term care facility? The answer is easy: It’s because the overwhelming majority of nursing home residents have a diagnosable psychiatric disorder, most often a dementia such as Alzheimer’s disease, or depression, usually as a complication of disabling medical conditions. Patients with chronic and severe mental illnesses that began for the first time earlier in life are present in nursing homes, but they are much less common.

Some have suggested that because of the high rates of psychiatric illness among their residents, nursing homes can, in fact, be viewed as psychiatric facilities. This might make sense in terms of the problems experienced by most of the residents. However, it is certainly not the case in terms of the design of nursing homes, the organization of the services provided, and the nature of staff training. It is in this context that this Handbook is an important book. It is designed to fill the gaps between what nursing home residents need, and the care that most facilities are designed to provide.

The Handbook can be viewed as a toolkit. It is a useful textbook on geriatric mental health that provides readable background information and practical guidance on the evaluation and management of the mental health problems that are common in nursing homes. It can also serve as an up to date text for courses on mental health in gerontology programs, and as a study guide that nurses, social workers, and administrators in nursing homes can use to educate themselves about these issues. In addition, the design of the Handbook makes it useful as a resource for educators and program directors. The key points listed at the start of each chapter can serve as outlines for in-service education, and the case examples spread throughout the book are valuable as discussion points for seminars or staff meetings. Finally, the family information sheets are important as tools for educating the residents’ families about mental health treatment, and also as a means for facilitating communication between staff and families.

It is important for those working in nursing homes and other long-term care facilities to be knowledgeable about the psychiatric disorders of late life and to view their jobs in terms of their roles in what have been described as two separable but interacting mental health care systems within nursing homes. One is a professional or extrinsic system within which psychiatrists, psychologists, or other health or mental health care professionals evaluate, diagnose, and treat residents with specific psychiatric disorders. As described in the Handbook, this is the system that evaluates residents to look for medical causes for mental disorders and establishes psychiatric diagnoses. It provides psychotherapy or prescribes antidepressants for residents with depression, and designs behavioral treatment protocols and prescribes medications when they are needed for those with behavioral and psycho-

logical symptoms of dementia. For this system to work effectively, there must be close collaboration between the behavioral health professionals and the nursing home staff. To ensure that residents get the treatment they need, all staff members should be active in recognizing mental disorders and behavioral symptoms, and facilitating referrals for evaluation and treatment. Even after the referral, support and information from the staff is necessary to allow the mental health professional to establish diagnoses and plan treatments. If the clinical concern is the acute onset of confusion or a sudden worsening in cognitive status, a diagnosis of delirium requires staff input about the nature of the resident's deterioration and about the extent to which his or her behavior varies over the day. When the concern is about depression, staff input about the persistence of the resident's depressed mood and about symptoms such as mood reactivity, sleep, and appetite are necessary to complement the professional's own observations. When the concern is about psychological and behavioral symptoms of dementia, staff input about the nature of the behavioral symptoms, the presence or absence of hallucinations, delusions or depression, and behavioral observations about the frequency of specific behaviors, as well as their antecedents and consequences are needed to allow treatment planning. The staff's role also remains important after diagnosis and the initiation of treatment. Their role in the delivery of behavioral treatments is obvious. In addition, they are critical for educating patients and families about treatments, encouraging adherence, monitoring the outcome of treatment, and observing residents for early signs of drug side effects.

The second mental health care system is an intrinsic one. It is the sum total of the responses of nursing homes or care facilities in terms of policies, programs, and procedures for the delivery of care. Critical elements of this system for residents with dementia include activity programs that can help structure time for those who have lost their ability to initiate activities on their own. It also includes attention to each resident's cognitive deficits and residual abilities, staff communication and the way that basic nursing services are delivered. Everyone who has worked with patients suffering from dementia can recall interactions between residents and staff members that led to frustration or agitation. Perhaps the staff did not realize that the resident could not follow directions because they had an aphasia that prevented them from understanding verbal instructions, or possibly they had an apraxia that kept them from being able to translate thoughts into complex actions. All too often, residents become anxious because they can not understand what is being said or they can not perform what is being asked. In turn, the staff member repeats the request, perhaps accompanied by signs of frustration, and the resident's discomfort escalates, often with agitation or aggression. The best way to prevent such events is to be sure everyone who works in nursing homes can recognize the cognitive deficits that occur in dementia, and can adjust their interactions with residents accordingly. Other important skills include recognizing when residents are experiencing distress, and learning how to modify interactions to prevent escalation to agitation or aggression.

Another function of the intrinsic mental health system is to prevent demoralization, depression, and deterioration by helping residents experience a sense of control over their own lives. For cognitively intact residents who are dependent as a result of physical disabilities, it is a major challenge to deliver nursing care in a manner that helps to preserve a sense of autonomy and control. The key must be to honor the resident's preferences about daily routines and to provide as much choice as possible about care alternatives. When it

is not possible to honor such preferences or provide choices, this should be explained, and residents should be given as much prior information as possible about the necessities of care. For residents with cognitive impairment, this challenge is even more difficult. Here, the task must be to provide as much choice as possible, but not so much as to overwhelm the resident's ability to make decisions. It might not, for example, be possible for a resident to answer the question, "What would you like to wear today?" and it might be more appropriate to ask, "Would you like to wear the blue sweater or the green one?" It is also important for staff members to know enough about who each resident is or was to be able to interact with them as unique individuals. Alzheimer's disease has been described as an illness in which cognitive deficits lead patients to lose their "sense of self." In this context, individualizing staff interactions with residents, referring to their biographical identities and helping them to maintain the preferences and patterns that were important to them, may help them to preserve this "sense of self," in spite of the progression of their dementia. For more intact residents, this may involve knowing and talking about their families, hobbies, or past work experiences. For more impaired residents, this may include behavioral approaches such as giving simplified arithmetic problems to a retired accountant, cloth for a tailor to sew, or laundry for a housekeeper to fold.

This Handbook provides the knowledge base to allow staff members of nursing homes and long-term care facilities to participate in both the professional and the intrinsic mental health systems. Which staff members should learn about mental health? Here, too, the answer is easy: Everyone. For nurses, administrators, and social workers, this knowledge is important; the Handbook should be required reading. For the nursing assistants or aides who have the most frequent direct contact with residents, it is even more critical. But the importance of knowledge about mental health is still broader. Everyone who has contact with residents, including those who work in food service, housekeeping, maintenance, and building security should be aware of the mental disorders of late life. They should know at least enough to help identify patients who may need medical evaluations or psychiatric referrals, by reporting acute changes in mental status or behavior which suggest the presence of depression or psychosis. In addition, as part of the intrinsic system, they should know enough to be able to recognize when their interactions with residents lead to agitation or suspiciousness, to understand that these are symptoms of mental disorders, and be aware of how to avoid further escalations. As a first step in disseminating knowledge about mental health throughout the long-term care facility, use of the Handbook as a toolkit should help to deliver the simplest possible messages to the largest possible group.

In using this Handbook as a resource, it is important to recognize that it is written to convey two basic messages. The first and most explicit is that psychiatric disorders are common in nursing homes and other long-term care facilities, and that their evaluation, diagnosis, and treatment can lead to a decrease in suffering and improvements in the quality of life for many residents. Although the focus of this Handbook is on the serious illnesses, the second message, mostly implicit, is highly optimistic. It *is* possible for nursing home residents to lead a good life, in spite of their illnesses and disabilities, if their mental health needs are met. This requires that the staff and mental health professionals work together effectively to ensure that psychiatric disorders such as delirium, depression, psychoses, and the behavioral and psychological symptoms of dementia are recognized and treated appropriately. It also requires that the day-to-day programming and the moment-



to-moment care that characterize the intrinsic mental health system work, not just to manage behavioral disturbances, but to help residents maintain their autonomy and sense of self to the fullest possible extent.

Ira R. Katz, M.D., Ph.D.

Professor of Psychiatry, University of Pennsylvania; Director, Section of Geriatric Psychiatry, and Director, Mental Illness Research, Education and Clinical Center, Philadelphia VA Medical Center

# Preface

The impetus for the original version of this book came from the positive response of staff who attended a seminar series entitled “Practical Psychiatry in Long-Term Care,” presented by the Psychiatry Consultation-Liaison Team at Baycrest Centre for Geriatric Care in Toronto, Canada, in 1989. In view of the lack of available literature in this area, we decided to write a book based on the contents of this course with the addition of several new topics.

The first version of this book was published in 1992 with the title “Practical Psychiatry in the Nursing Home.” In recognition of the widening range of institutions for the care of the elderly, the title of the second revised and expanded edition in 2001 was changed to “Practical Psychiatry in the Long-Term Care Facility.” This third edition contains four new chapters focusing on alcohol use and misuse, sexuality and sexual behavior, group psychotherapy, and guidelines. Our intention has always been to produce a book that is practical, understandable, clinically relevant, “user friendly,” and as jargon-free as possible. We hope that the book will continue to be useful for the staff of all long-term care facilities for the elderly, including nursing homes, homes for the aged, chronic care hospitals, and residential centres.

The prevalence of mental disorders in the residents of these facilities is very high and the staff, residents, and their families alike struggle with the problems associated with these disorders on a daily basis. We have aimed this book at all staff members and hope that it will be equally relevant to nurses, nursing aides, physicians, social workers, psychologists, occupational therapists, and all the other staff of these facilities. We are hopeful that the book will be used as a tool for both continuing education of staff and for the teaching of undergraduate students.

The book utilizes numerous clinical case examples, with an emphasis on practical management strategies. We have outlined questions that are frequently asked by staff and have attempted to respond to these questions. The chapters conclude with key points. We have avoided the use of excessive references and a list of suggested reading can be found at the end of each chapter. For several chapters we have added an information sheet, which can be photocopied and distributed to family members.

The case illustrations are composites of residents seen by the authors. They have been disguised to ensure anonymity. For the most part, we have preferred to use the term “resident” rather than “patient” in order to underline the fact that for these individuals the institution is their home, and like all of us, they are only “patients” when requiring medical care.

The authors include psychiatrists, nurses, a psychologist, and a social worker. We have tried to emphasize a biopsychosocial model throughout the book and a multidisciplinary approach to the management of these residents.

We are aware that the availability of mental health professionals in long-term care settings is variable, and often minimal. In the majority of institutions, front line staff have to “make do” without the help of consultants or staff trained to manage mental disorders. We

are hopeful that the ideas and information contained in this book can be utilized by front line staff in their day-to-day management of residents with mental disorders. We have tried to emphasize that for any given problem there may be a variety of potential interventions. Often the best results occur following the introduction of several complementary management strategies. Because many of the problems in long-term care are by their very nature chronic, it is easy to slip into a pessimistic, or even nihilistic, frame of mind. This book tries to show that many of these problems can be managed successfully and that we *can* make a difference.

We have received a great deal of positive feedback regarding the usefulness of the first two editions. If you have any comments on how to improve future editions of this book, please contact David Conn at [dconn@baycrest.org](mailto:dconn@baycrest.org) or at the Baycrest Centre for Geriatric Care, Department of Psychiatry, 3560 Bathurst Street, Toronto, Canada, M6A 2E1.

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# Table of Contents

Foreword by Ira R. Katz . . . . .	v
Preface . . . . .	ix
Acknowledgments . . . . .	x
Contributors . . . . .	xi
Chapter 1      Mental Health Issues in Long-Term Care Facilities . . . . .	1
<i>David K. Conn</i>	
Chapter 2      The Mental Status Examination . . . . .	17
<i>Barbara Schogt, Dmytro Rewilak</i>	
Chapter 3      Alzheimer's Disease and Other Dementias . . . . .	37
<i>Nathan Herrmann, Robert Madan</i>	
Chapter 4      Delirium . . . . .	57
<i>Barbara Schogt, David Myran</i>	
Chapter 5      Mood and Anxiety Disorders . . . . .	79
<i>David K. Conn, Alanna Kaye</i>	
Chapter 6      The Suicidal Resident . . . . .	103
<i>David K. Conn, Alanna Kaye</i>	
Chapter 7      The Suspicious Resident . . . . .	121
<i>Barbara Schogt</i>	
Chapter 8      The Resident with Personality Disorder . . . . .	139
<i>Anne Robinson, Barbara Schogt</i>	
Chapter 9      Alcohol Use and Misuse . . . . .	155
<i>Ken Schwartz</i>	

<b>Chapter 10</b>	Sexuality and Sexual Behavior . . . . .	169
	<i>Ken Schwartz, David Myran, Marcia Sokolowski</i>	
<b>Chapter 11</b>	Principles of Geriatric Psychopharmacology . . . . .	183
	<i>Nathan Herrmann</i>	
<b>Chapter 12</b>	Optimizing the Use of Psychotropic Medications . . . . .	203
	<i>David K. Conn</i>	
<b>Chapter 13</b>	Behavior Management Strategies . . . . .	217
	<i>Dmytro Rewilak</i>	
<b>Chapter 14</b>	Psychotherapy for the Institutionalized Elderly . . . . .	239
	<i>Joel Sadavoy</i>	
<b>Chapter 15</b>	Groups and Group Psychotherapy . . . . .	257
	<i>Ken Schwartz</i>	
<b>Chapter 16</b>	Guidelines for the Assessment and Treatment of Mental Health Issues . . . . .	267
	<i>David K. Conn, Maggie Gibson</i>	
<b>Chapter 17</b>	Planning Mental Health Educational Programs . . . . .	279
	<i>Susan Lieff, Ivan Silver</i>	
<b>Chapter 18</b>	Helping the Nursing Staff: The Role of the Psychogeriatric Nurse Consultant . . . . .	289
	<i>Alanna Kaye, Anne Robinson</i>	
<b>Chapter 19</b>	Understanding and Helping the Family . . . . .	299
	<i>Etta Ginsberg-McEwan, Anne Robinson</i>	
<b>Chapter 20</b>	Legal and Ethical Dimensions . . . . .	311
	<i>Michel Silberfeld</i>	
<b>Index</b>	. . . . .	323

# 1

## Mental Health Issues in Long-Term Care Facilities

David K. Conn

### Key Points

- The prevalence of mental disorders in residents of long-term care facilities is at least 80%.
- Common problems include depression and behaviors associated with dementia, such as verbal and physical aggression, wandering, and physical resistance to care.
- Very few residents ever receive care from mental health professionals.
- The biopsychosocial model of care is helpful both in the understanding of the problems and in the planning of individualized care.
- Staff vigilance and the use of screening instruments can facilitate the early recognition and prevention of psychiatric/emotional disorders.

### History

The characteristics of long-term care facilities for the elderly have changed dramatically over the past 100 years. Until the 20th century most facilities for the aged were primitive, badly run, and offered only custodial care.

Institutions for the disabled and infirm date all the way back to the third or fourth century AD [1]. Such facilities developed initially in the Middle East, and over many centuries the concept subsequently spread to Western Europe. By medieval times it was common that the aged and sick were cared for by a variety of religious orders in monasteries, often in remote locations.

In England and Wales, as monasteries disappeared in the 1500s, responsibility for the poor was gradually taken on by the local parishes. Under the Poor Relief Act in 1601, poor houses were established for those who were blind, disabled, mentally or physically ill, as well as the destitute. These poor houses were also referred to as work houses because they



were a source for cheap labor. By the nineteenth century between one-third and one-half of the occupants in a typical work house were elderly or “impotent” persons.

With the development of our modern concept of a hospital in the nineteenth century, the primary emphasis was placed on the treatment of the acutely sick, rather than the chronically ill, and completely separate institutions were established for “the insane.” In other institutions, the elderly, the poor, the chronically sick, and the disabled were crowded together in appalling conditions, often with vagrants and the destitute. By the beginning of the twentieth century, there was clearly a growing need for convalescent and chronic care beds. It was only at this point that the modern concept of the nursing home was firmly established, modeled on the general principles of the sanatorium. The early nursing homes were occasionally attached to general hospitals, but more frequently they were built as completely separate institutions, usually some distance from the closest city.

## Trends

With the growth of the elderly population in modern industrial countries, the number of people receiving care in nursing homes has been rising dramatically. In the United States, for example, the number of beds in such facilities has more than tripled during the past 25 years, and now totals over 1.7 million. This growth in the number of nursing home beds (1963–1995) is shown in **Figure 1**. The average length of stay in a nursing home is 2.5 years and approximately 25% of the population will be admitted to a nursing home at some point during their lives.

The continuing growth of the elderly population in the U.S. is shown in **Figures 2 and**

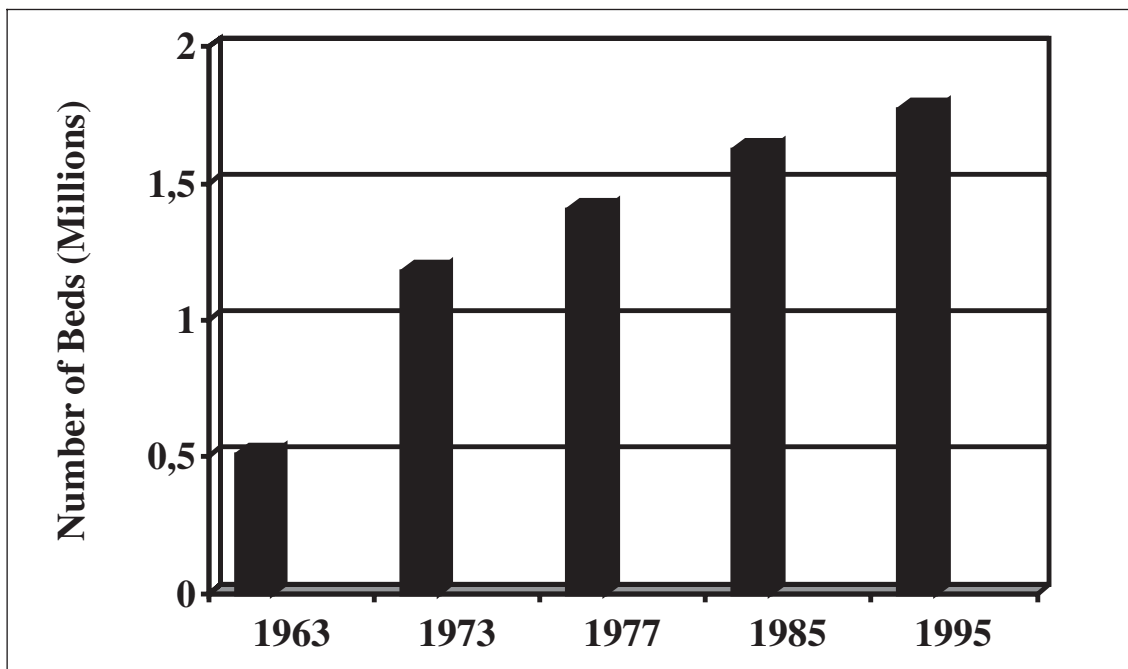
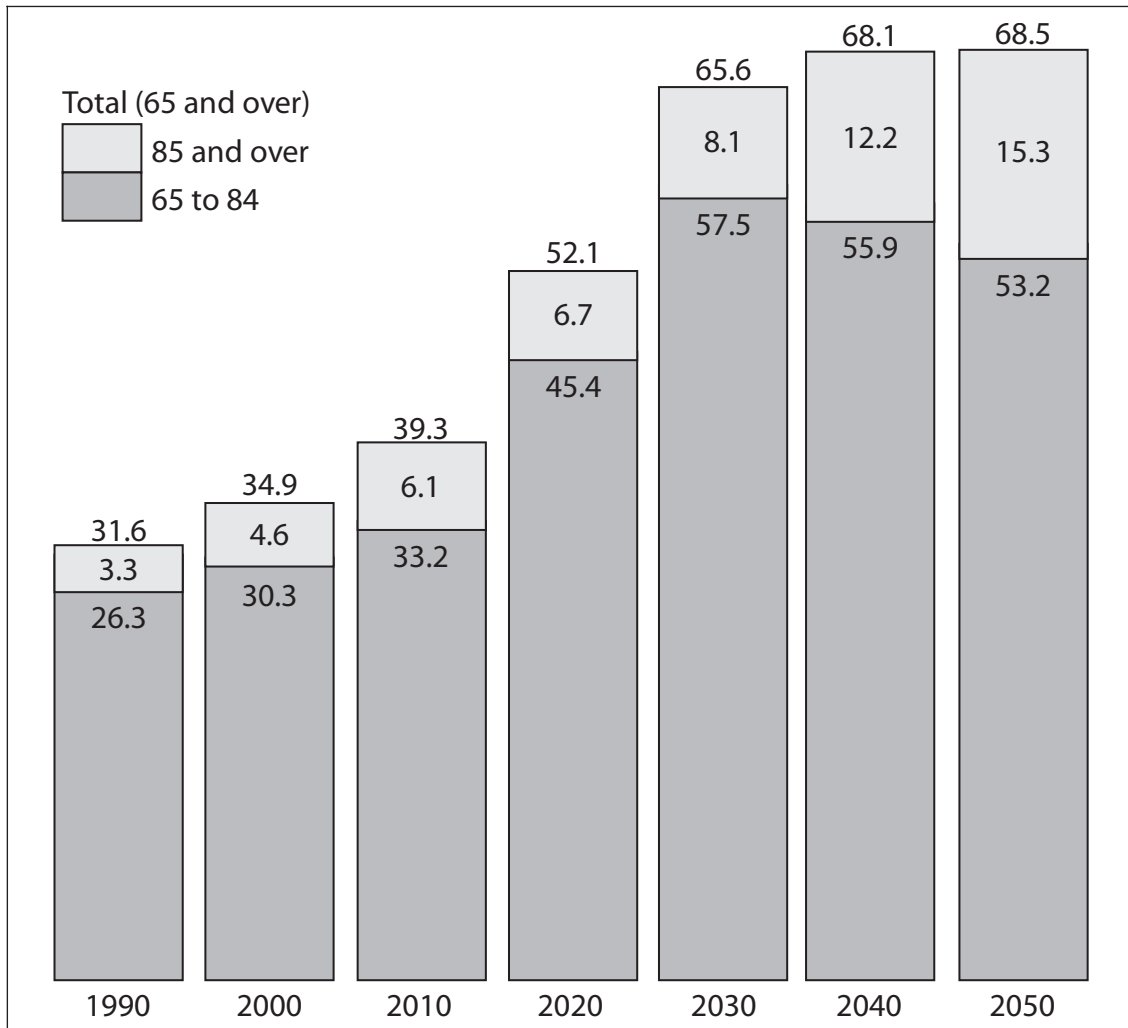


Figure 1 Number of Nursing Home Beds, United States, 1963–1995. [Refs. 3, 29, 30]



**Figure 2** Projections of Elderly Population, by Age, 1990–2050 (Middle Series Projections, in Millions). [Ref. 31]

**3.** It is projected that the population 65 years and over will grow at a sustained 1.2% per year until 2010. After 2010, however, the rate of growth will increase in a more striking manner as the Baby Boom generation enters old age.

The phenomenal projected growth of the population 85 years and over is shown in **Figure 3**. It is of course this age group that is most likely to require long-term care. The continuing increase in life-expectancy at age 65 is demonstrated in **Figure 4**. Accordingly the projected growth in requirements for nursing home and other long-term care beds is illustrated in **Figure 5**.

There are many important trends in this field which are particularly influenced by these changing demographics. Seven of these trends, which will have a critical impact on the future of long-term care include:

- A growth in the physical size of facilities
- A greater focus on the need to optimize the environment (physical space and activities)

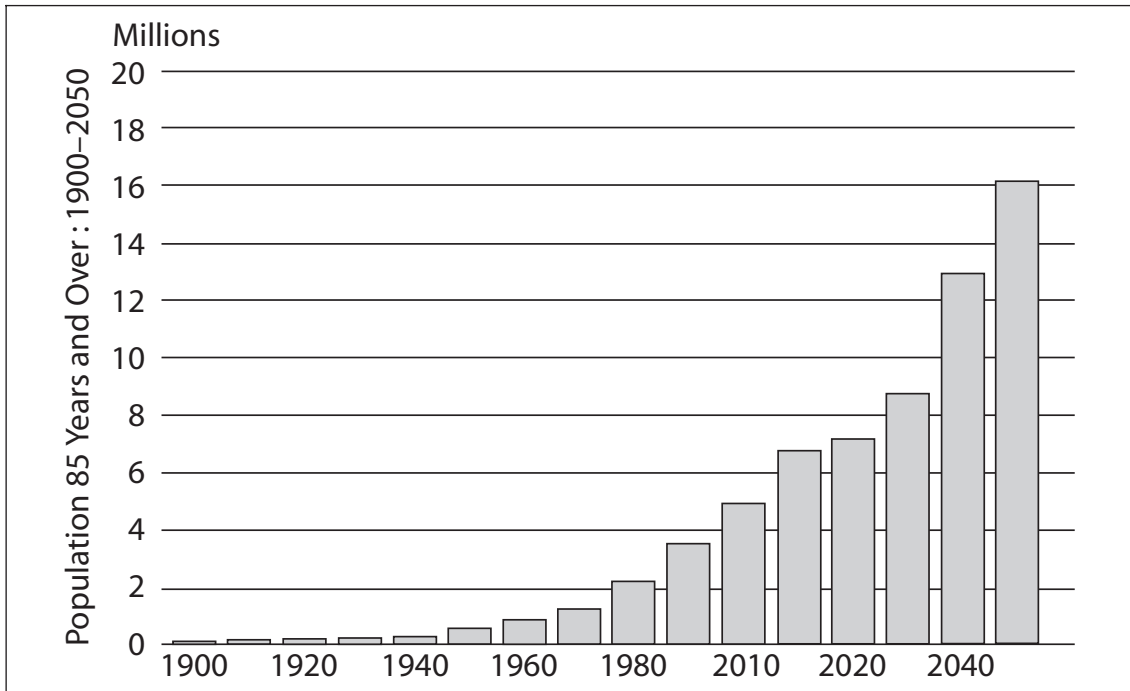


Figure 3 Population 85 Years and over, 1990–2050. [Ref. 32]

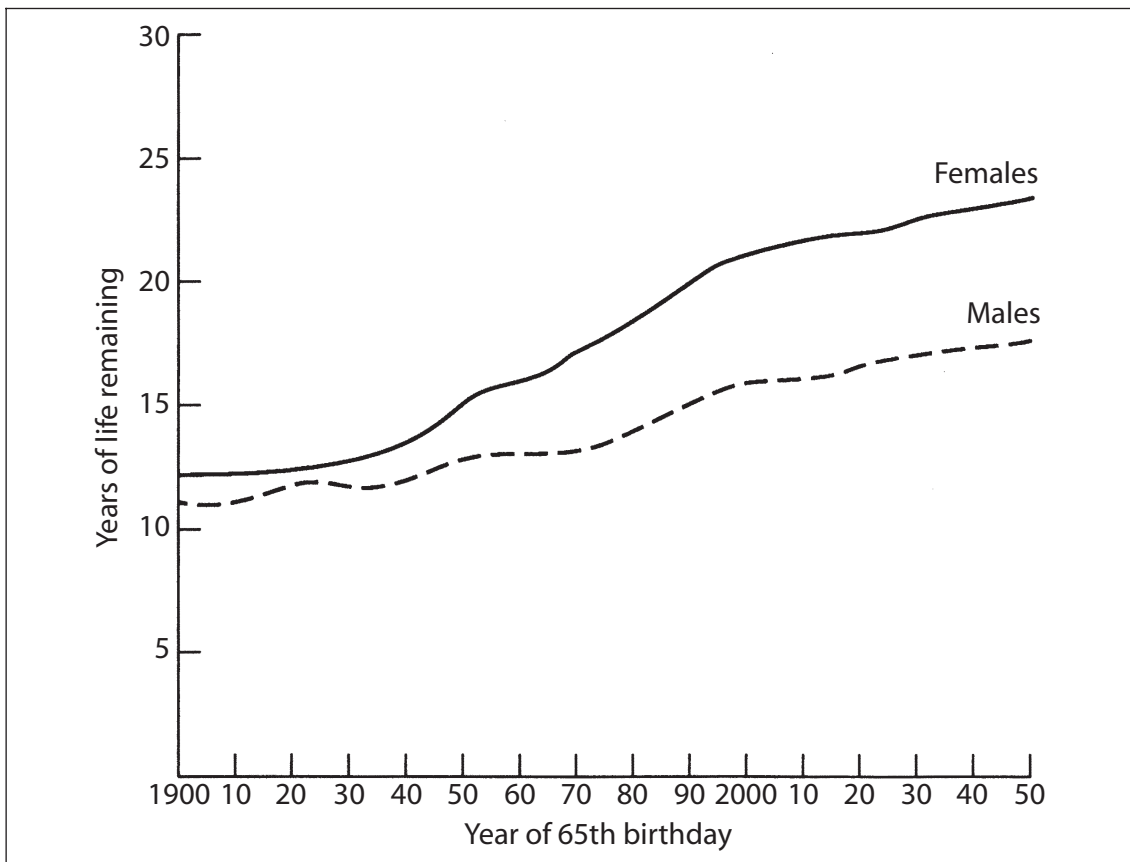


Figure 4 Life Expectancy at Age 65. [Ref. 32]

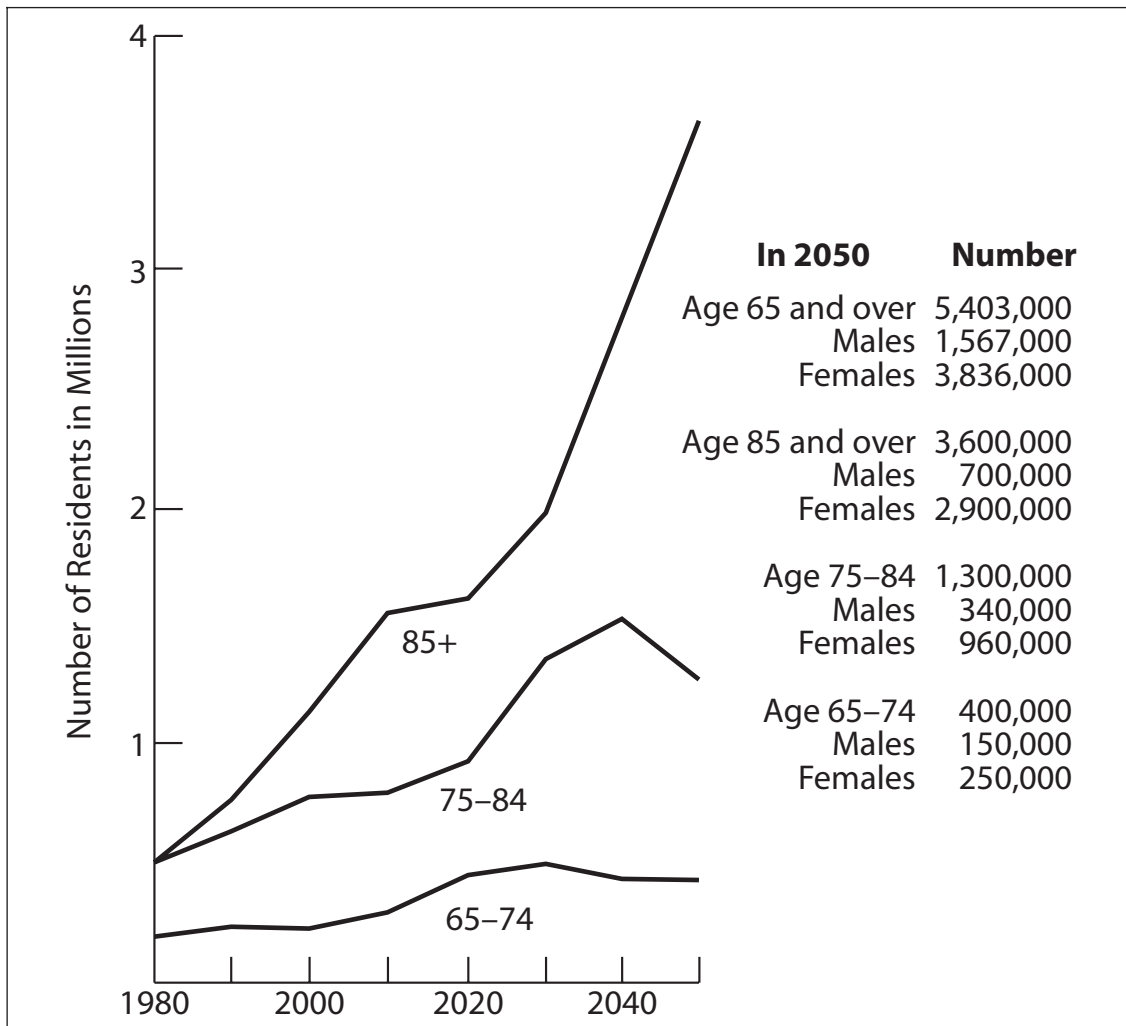


Figure 5 Projected Number of Nursing Home Residents in the United States by Age, 1980–2050. [Ref. 33]

- An increase in the availability of high levels of care
- A significantly greater percentage of residents with dementia and severe cognitive impairment
- More residents with psychiatric and behavioral disorders
- Greater involvement of university programs in nursing homes, with the development of the so-called “teaching nursing home”
- Increased legislation (e.g., OBRA 1987 in the U.S.) to ensure higher standards of care and the development of best practice guidelines

## The Residents

There is considerable evidence that most elderly residents of nursing homes do in fact need a great deal of care and assistance. For example in the 1995 U.S. National Nursing Home

Survey 96.9% of residents required assistance with at least one activity of daily living [2]. 96% required assistance in bathing, 86% in dressing, 58% in toileting, and 45% in eating. It is clear that one's ability or inability to perform the activities of normal daily living contributes substantially to the final decision regarding admission to a nursing home.

As of 1995 there were approximately 16,700 nursing homes operating in the United States, consisting of a total of 1.77 million beds [3]. These institutions are categorized federally as Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs). It is estimated that currently, 1 in 10 persons aged 75 and older, and 1 in 5 aged 85 and older are living in nursing homes. Expenditures for nursing home care in 1997 in the U.S. were estimated at 82.8 billion dollars, out of a total of 1.1 trillion dollars in personal health care. In this context, about 38% of this expenditure was private spending and the rest was public.

To deal with these powerful demographic and economic forces, various governments are trying new approaches. For example, in Canada the province of Ontario has attempted to reform long-term care based on certain key guiding principles, one of which states that:

“an increasing proportion of the elderly and people with physical disabilities who require health and social services will receive them in their own homes, to avoid both inappropriate use of acute care beds and unnecessary growth in the number of extended and chronic care beds.”

But in spite of this well-founded goal of attempting to maintain the elderly in the community for as long as possible by increasing the availability of community care and supports, the unstoppable demographic realities we now face, as well as the cumulative ravages of illness and old age, will lead to an increased requirement for long-term care beds.

In dealing with these strategic planning issues, it is often suggested that children frequently abandon or ignore their elderly parents, but this is just a myth. In fact families remain the primary source of care for the vast majority of frail parents, and this burden is especially carried by daughters, who are themselves also often trying to care for young children. However, as the demand for care increases, most often as a result of progressive mental impairment, it frequently becomes an impossible burden for the family, and institutional care becomes a necessity.

## Prevalence of Psychiatric/Behavioral Disturbances

Studies suggest that while 80% or more of elderly nursing home residents suffer from some form of mental disorder, only a very small percentage ever receive any care from mental health professionals. During the 1960s hundreds of thousands of psychiatric patients were discharged from state mental hospitals, especially in the U.S. This happened partly because of pressure from groups who felt that such individuals should live in the community, and partly because advances in drug therapy allowed even severely ill patients to function at reasonable levels. But many of these former patients, especially those who were elderly, were not able to care for themselves, and as a result ended up being transferred to nursing homes, which were expected to continue the appropriate care and

management of these patients, even though such homes were not staffed or funded to provide mental health care.

The U.S. National Center for Health Statistics reported in 1977 that approximately 20% of all nursing home residents had a mental disorder (psychiatric illness or dementia) as their primary source of disability, and that nearly 70%, which was more than 900,000 residents, had a chronic mental disorder which contributed to social dependency, functional impairment, and need for nursing home care [4]. Two thirds of all residents were found to have behavioral problems, most commonly agitation or apathy. In one important study, Rovner and his colleagues found that 76% of their sample of nursing home residents showed at least one problem behavior, while 40% displayed five or more such difficulties [5]. Another study, performed in New York City [6], found that the three most common behavior problems in nursing homes for the aged, were verbal abuse, physical resistance to care, and physical aggressiveness.

Similarly, a survey in Ontario, Canada [7] found that the most common behavior problems were agitation, wandering, and depression, whereas the problem of greatest concern for staff was physical aggression. Yet in spite of these statistics, surveys suggest that few patients with a diagnosable mental disorder receive care from mental health professionals.

In addition to the distinct lack of psychiatric care for nursing home residents, several investigations suggest that psychotropic drugs are overused in this population: 50% to 80% of residents commonly receive psychotropic agents [8, 9]. A study of physicians' prescribing practices surveyed the records of 173 nursing homes and revealed that 43% of almost 6,000 residents had prescriptions for an antipsychotic medication [10]. Incredibly, the average dose per resident turned out to be directly related to the size of the nursing home, and the size of the prescribing physicians' caseload. It is clear that more research is needed in order to determine the appropriate use of these medications.

## Common Psychiatric and Emotional Problems

It appears that the majority of residents with psychiatric problems in the nursing home setting suffer from some form of underlying primary brain disease. The most common of these disorders is dementia, and the most common cause of dementia is Alzheimer's disease, followed by vascular dementia. Dr. Alzheimer himself, in his initial description of dementia, emphasized the development of behavioral disturbances. His descriptions included paranoid delusions, hallucinations, unfounded jealousy, hiding of objects, and screaming. Dementing disorders are often associated with disruptive behavior, including physical and verbal aggression, anger, paranoid ideation, wandering, insomnia, and incontinence. A study of 126 patients with dementia [11] found that 83% of them exhibited one or more such behavior problems. Rovner et al. reported the prevalence of specific psychiatric disorders in 454 consecutive nursing home admissions (see **Table 1**) [12]. 67.4% had a dementia and 10% had an affective disorder. 40% of patients with dementia had additional psychiatric syndromes.

Depression is another common mental problem in the nursing home setting. Depressive symptoms occur in approximately 15% of the elderly in the general community, although the prevalence rate for major clinical depression is probably 2% to 4%. In contrast, studies

**Table 1** Prevalence of Dementia and Other Psychiatric Disorders in New Admissions to Nursing Homes (N = 454)

Diagnosis	n	%
<i>Dementias complicated by depression, delusions, or delirium</i>		
Primary degenerative dementia of the Alzheimer's type		
with delusions/hallucinations	43	9.5
with depression	7	1.5
with delirium	15	3.3
Multiinfarct dementia		
with delusions/hallucinations	14	3.1
with depression	8	1.7
with delirium	14	3.1
Dementia plus depression	14	3.1
Other dementias		
with delusions/hallucinations	4	0.9
with delirium	4	0.9
Subtotal	(123)	(27.1)
<i>Dementia only</i>		
Primary degenerative dementia of Alzheimer's type	122	26.9
Multiinfarct dementia	59	13.0
Other dementias	2	0.4
Subtotal	(183)	(40.3)
<i>Other psychiatric disorders</i>		
Affective disorders	47	10.4
Schizophrenia/other	11	2.4
Subtotal	(58)	(12.8)
<i>No psychiatric disorder</i>	90	19.8
TOTAL	454	100.0

From B.W. Rovner et al. (1990). The prevalence and management of dementia and other psychiatric disorders in nursing homes. *International Psychogeriatrics*, 2:13–24. Reprinted with permission of Cambridge University Press.

suggest that between 15% and 25% of nursing home residents have symptoms of major depression, and another 25% have depressive symptoms of lesser severity [13, 14]. The recognition and diagnosis of depression is particularly important because it is a treatable condition; unfortunately, on occasion untreated depression can lead to extreme morbidity and ultimately to death.

## Diagnostic Classifications

The diagnoses used in this book are based on the American Psychiatric Association's diagnostic system, entitled DSM-IV-TR [15]. It is a multi-axial system with Axis I containing the major psychiatric diagnosis, Axis II containing personality traits and disorders, Axis III the medical illnesses, Axis IV the level of psychosocial stress, and Axis V the level of functioning of the individual. **Table 2** lists common DSM-IV-TR diagnoses seen in long-term care residents.

**Table 2** Common Psychiatric Diagnoses in Residents of Long-Term Care Facilities

- Dementia
- Delirium
- Mood disorder due to a general medical condition
- Psychotic disorder due to a general medical condition
- Personality change due to a general medical condition
- Major depression
- Dysthymic disorder
- Adjustment disorder
- Personality disorder

## Models of Care

The “biopsychosocial” model, in contrast to the biomedical approach, is the model of choice in both geriatrics and psychiatry. In formulating a clinical situation, it is often helpful to categorize etiological factors into biological (physical), psychological, and social categories, as illustrated in **Figure 6**. The category “social” includes both cultural and environmental factors. This model then allows for the design of treatment interventions aimed at a variety of factors.

In some institutions models which favor one or another professional orientation, such as a “social work model” or a “nursing model,” are preferred. It is the conclusion of the authors of this book that a biopsychosocial approach, which attempts to understand a resident's problems from a variety of different perspectives, makes the most sense. Inherent in any model of nursing home care is an acceptance of reasonable goals, and an emphasis on “care not cure.” Lawton tries to define “the good life” for nursing home residents, and outlines the components of such an experience, which include behavioral competence, psychological well-being, and quality of life and of the objective environment [16]. These are translated into goals of health, happiness, satisfaction with daily life, and a comfortable environment.



## Case Illustration

Mrs. A., an 89-year-old widow, had been admitted to the nursing home two months previously. She was born in England, emigrated to Canada shortly before the First World War, and had worked as a secretary prior to her marriage to a tailor. They had a "solid," happy marriage, and two children. Mr. A. had died one year earlier of a stroke. Mrs. A. was having difficulty functioning in her own apartment, and was neglecting herself to the point that finally her daughter arranged for an application and placement at the home. Mrs. A. had not adjusted well to the new environment, and had been weepy, distressed, and agitated at times. She appeared unmotivated and disinterested in activities and programs. She was sleeping poorly, not eating, and stated clearly that she wanted to die. Her daughter was away in Florida, and her son lived out of town. Mrs. A. had a past history of hypothyroidism and of postpartum depression. Her own mother was described as having had "bad nerves," and her son had required treatment for depression. Mrs. A. had a history of losses early in life, including the death of her mother when she was 8 years old. She was cared for by an aunt until her father remarried, and she subsequently had a poor relationship with her stepmother. Mrs. A. described frequent episodes of mild depression for many years but never sought professional help. It was worthy of note that the unit itself was under some stress due to illness among the staff, including the head nurse. There was also some disruption on the floor because of renovations that were underway.

## Comment

In order to understand the possible reasons for Mrs. A.'s depression and grief it is helpful to use the framework described in Figure 6. This approach can be helpful both in understanding the situation and in developing a management plan. In the case of Mrs. A., predisposing factors for depression include a biological vulnerability based on a positive family history of mood disorder, and a previous history of hypothyroidism. She is also psychologically predisposed because of her early life losses, especially the death of her mother, and deprivation. Major precipitants include her recent admission to the institution and the death of her husband one year earlier, producing an "anniversary reaction." Recent problems on the unit may also have led to less available support from staff. Factors which could perpetuate the depression include her poor adjustment to the home, her apparent inability to develop new relationships, and her long-standing history of depression. Management steps based on our approach would include medical investigations, such as thyroid function, antidepressant medication, supportive psychotherapy, and attempts to encourage her to participate in recreation programs. With the introduction of appropriate treatment, the return of her daughter from vacation, and the restabilization of the unit, her prognosis would probably be good.

	Biological	Psychological	Social
Predisposing			
Precipitating			
Perpetuating			

Figure 6 The Biopsychosocial Model: A Grid for Formulation

## What Are the Components of Good Care?

Attempts to understand and support the biological, psychological, and social needs of the resident provide a solid foundation for good care. Edelson and Lyons emphasize the need to individualize care and promote a sense of mastery in the residents in order that they can feel a sense of trust in and some control over their environment [17]. They stress in particular the importance of understanding the meaning in the impaired resident's behavior. They also point out that an understanding of "the system" is critical and that an institution is like a living organism. One must battle against nihilism, cynicism, and resistance to change which is often present in geriatric institutions. Borson and colleagues note that long-term care "emphasizes maintenance of functional capacity, delaying the progress of disease when possible, and the creation of a safe, supportive environment that promotes maximal autonomy and life satisfaction. The over-arching philosophy of good long-term care is the preservation of dignity and purpose in the face of dependency and decline" [18].

## Potential Problems in the Care of Nursing Home Residents

There has been growing public criticism regarding care in nursing homes. A series of books with titles such as "Warehouses of Death" have presented searing indictments of nursing home care [19]. There have been accounts of mistreatment and abuse of the elderly,

poor medical/nursing care, and even greed, particularly in the private sector. In spite of this, considering the funds available, the staff of the majority of nursing homes do an admirable job under trying conditions. However, there are still problems to be solved, and these problems include:

- Poor staff/resident ratios
- Lack of qualified professional staff
- Low morale among staff
- Poorly designed and aging facilities
- Lack of commitment from society and government to direct appropriate funds to this population

## Legislation and Regulations in the United States

Concerns about poor care, misuse of physical restraints and psychotropic medications, as well as inappropriate placement of some residents led to Federal legislation in the United States, termed the Omnibus Budget Reconciliation Act of 1987 (OBRA 87). The Health Care Financing Administration (HCFA) issue regulations [20] and individual states are responsible for enforcing these laws. This is achieved by the use of surveys based on operational criteria.

The regulations require Preadmission Screening and Annual Resident Review (PASARR). If an applicant is found to suffer from a serious mental disorder, then a determination of treatment needs and appropriate level of care must be made. The requirement for comprehensive assessment led to guidelines for the administration of the Minimum Data Set (MDS), or equivalent instrument. One potential weakness of the MDS is a tendency for the instrument to misrepresent the degree of mood or behavior disturbance present [21]. The results of the MDS may trigger the use of Resident Assessment Protocols (RAPs) that define common disorders, disabilities or functional impairments and outline procedures for appropriate evaluation and management. RAPs, which are particularly relevant to mental disorders, include cognitive loss/dementia, delirium, psychosocial well-being, mood state, behavior problems, psychotropic drug use, and physical restraints. The regulations also restrict the use of physical restraints and provides strict guidelines for the use of psychotropic medications, particularly antipsychotics (see Chapter 12)

## Creation of Best Practice Guidelines and Consensus Statements

In several countries guidelines which focus on mental health problems in long-term care homes have been created, generally by multidisciplinary groups [22, 23, 24]. Canadian guidelines, which were released in 2006 are described in Chapter 16.