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“Caring Well for Residents with Mental Illness”

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Jessie is a woman in her early 60's with a diagnosis of Bipolar Disorder. She has lived in various nursing homes since being discharged from one of the state psychiatric hospitals where she'd been a patient since her mid-20's. She is currently receiving Zyprexa and Zoloft for her depression and delusions.

Jessie bursts into the Administrator's office, panting, faced flushed, "I need to talk to you right now, Mister. Pleaasee! My cousin was supposed to buy me a new dress and I haven't gotten it yet and she doesn't answer the phone when I call and I only have two dimes and you need quarters to use the pay phone. Mister! Pleaaaassee! I have to talk to you now!"

Administrator: "Jessie, I can't talk to you right now, I'm with someone."

Jessie, panting harder, fidgets with her clothes, quickly running her fingers through her hair, "Pleaassee, Mister, pleaaaassee! I have to...."

Administrator: "Jessie, I'm with someone now. I will talk to you later. Did you see the Social Worker?"

Jessie: "She doesn't talk to me. When I go to see her she tells me she's busy and she doesn't let me in the office they close the door and I call to her and she says, "not now" and Mister, pleaaaassee! Can't you call my cousin and ask her when she is going to send me my new dress? I really want it and I don't have any nice dresses and nobody ever buys me dresses and....." she begins to cry, cupping her hands, a last whimpering, "pleaassee?"

Administrator: "As soon as I'm finished, I will ask the Social Worker to talk with you. Why don't you go to the activity program in the main dining room until she calls you?"

Jessie gives him a long, sad look, then turns and leaves, defeated, muttering, "She won't call me she never wants to talk to me you don't like me either she won't call me....."

The next time we see Jessie she is standing outside the Social Worker's office loudly recounting her experience in the Administrator's office, "I just wanted him to talk to my cousin but he didn't want to talk to me. Nobody helps me (crying loudly), I don't have any friends here, and I hate it here! Ohhhh, pleaaaassee, somebody, call my cousin, pleaaaassee!"

The Social Worker and several other staff respond to her crying and offer brief comfort, "What's wrong? Shhhhh.....calm down. What happened?" As Jessie starts to tell her story and explain her sorrow, the staff attempts to quiet her which only incites her more. She begins yelling about how no one listens, how they all dislike her, how others get more attention than she does, and then she begins to cry uncontrollably.

This now becomes a "behavioral" event. The Doctor will be called and likely order a psychiatric consult. The staff will spend valuable time documenting and reporting on this event. Jessie will be a focus for several days as they watch for signs and symptoms of more behavior. This may even involve the staff in visual monitoring and documentation of Jessie's whereabouts and activity every half hour, or one-on-one supervision until they're sure the behavior has passed.

If they cannot prevent this behavior from recurring, or if it gets worse over time, they will look to find a "more appropriate environment" for Jessie. They will not consider that it might be their own ignorance of her illness and the way the symptoms of her illness manifest that causes her to behave in the way she does. They will not consider that their lack of appropriate response to her symptoms has fueled these "behaviors."

The numbers of residents diagnosed with mental illness living in nursing homes continues to grow. According to an article published by the National Institutes of Health in 2010, over the past decade, the proportion of new nursing home admissions with mental illness other than dementia, including major depression and serious mental illness, such as schizophrenia and other psychotic disorders, has overtaken the proportion with dementia only.¹

The Administrator's approach to Jessie might have been appropriate for someone without a long-standing mental illness. An illness that robs the person of control of their extreme emotions, that causes anxiety hard for others to understand, and that if not managed properly by knowledgeable caregivers will result in ongoing distress and "behavior" for Jessie.

What might have been more successful was to recognize and respond to her mania firmly, but with the understanding that she would need help to calm down. He could have offered Jessie a glass of water and asked her to sit in the outer office for five minutes until he was through. He then could have further calmed her by lowering his own voice, minimizing any distraction in the environment, and listening and responding to her concerns. He could have concluded by calling the social worker in and developing a solution that included regular appointments with the social worker for emotional support. Lastly, he could have contacted the Recreation Director to develop a daily activity plan for Jessie. Diversion, particularly activities that are productive and promote self-esteem are often successful in minimizing episodes of extreme emotion.

The NIH article discusses the meager education afforded nursing home staff in managing mental illness. Dementia has long been a focus of staff education and training in the general realm of behavior management, but mental illness rarely gets the same attention. For the vast majority of nursing home residents with mental illness who now have also been diagnosed with dementia, a lack of understanding about the impact of their underlying mental illness will make meeting their needs in their now demented state a bigger challenge.

The recommendations offered by the authors of a study on the quality of psychosocial services in nursing homes include greater scrutiny of how facilities are meeting the needs of this population. In their conclusion they assert that "the limited number of psychosocial care deficiencies cited is cause for concern as it reflects a lack of attention to an important dimension of resident care. OBRA 1987 requires facilities to provide social services in order to help residents attain or maintain "...the highest practicable physical, mental and psychosocial well-being."ⁱⁱ

The Federal government introduced the PASRR (originally entitled PASARR - Preadmission Screening and Annual Resident Review) in 1989. The Preadmission Screening and Resident Review is a two-phase screening and assessment process designed to identify and ensure delivery of appropriate services and placements for people with disabilities. Compliance with PASRR regulations require the facility to develop procedures for hiring, training and coordinating clinical teams for onsite evaluations and other psychosocial support activities.

The PASRR process was revised in 2009 based on the findings of a study conducted by the Office of the Inspector General (OIG) in 2007 into the quality of care for younger, mentally ill residents of nursing homes. The study found that barely a third of residents identified as requiring mental health services (Level II recommendations) were actually receiving those services in the nursing home. Evidence of consideration of community placements over the nursing home was also lacking.ⁱⁱⁱ

In tandem with a settlement reached by New York State of a Federal class action suit challenging placement of mentally ill patients in nursing homes, the PASRR process underwent further revision in 2011.^{iv} Level II assessment forms now prompt evaluators to consider community-based placements. Over the next three years, residents diagnosed with mental illness that could function in a less restrictive setting should be discharged to the community.

These changes are important for two reasons: 1) they require the facility to increase scrutiny of admission applications to ensure the appropriate Level I PASRR Screen has been completed and, where applicable, Level II recommendations forwarded prior to admitting a resident with mental illness or mental retardation, and 2) an increase in community placements will require nursing homes to improve staff education and training in the care of dependent residents with mental illness/mental retardation, particularly those that now also have dementia.

Review of deficiency citations in the areas of abuse prevention, quality of life, and mental and psychosocial well-being suggest that nursing homes continue to struggle with management of residents with mental illness. The more common challenges include managing antisocial behavior, preventing altercations between residents, addressing sexuality, and affording these residents the personal attention and guidance they often need to function at their best.

Two of the many pitfalls care teams face is a lack of education on mental illness and management strategies, and appropriate and timely communication between members of the clinical team. The NIH study found that Certified Nursing Assistants (CNAs) are the caregivers most likely to experience behavioral challenges, yet have the least amount of education and training on this topic.

Caring well for residents with mental illness begins with a solid knowledge base of diagnoses and symptoms. Understanding how bipolar disorder manifests and the symptoms one is likely to experience would have helped the Administrator respond to Jessie in more effective way.

The housekeeper needs to understand that the resident diagnosed with Obsessive Compulsive Disorder (OCD) will likely become upset when he/she starts insisting that the resident throw things away. The Dietitian needs to understand that the resident diagnosed with an eating disorder and major depression will likely not accept his/her

recommendations for improved nutrition. The CNA who is attempting ADL care for the resident diagnosed with paranoid schizophrenia and dementia needs to understand the importance of explaining what he/she is about to do before rushing through the task.

While most nursing homes work with psychiatry and psychology, as well as the interdisciplinary team on managing resident mood and behavior, the coordination of efforts is often lacking. For example, topics addressed in psychotherapy sessions can often help the team to understand the triggers to certain moods. Residents often discuss the things that upset them and, with the therapist's help, can identify the things they think may reduce the impact of these triggers.

Developing a successful plan of care requires understanding, communication, the ability to develop clear and specific person-centered goals and interventions, and the monitoring necessary to see that the plan is implemented and maintained. Consistency among the team in applying the interventions will be paramount to achieving the goals for improved mood and behavior.

Consider the following points in assessing your facility's readiness to care well for residents with mental illness:

1. Is the PASRR process understood by all concerned and in compliance with all Federal and State PASRR regulations?
2. Does staff receive comprehensive education and training in mental illness and the more complicated needs of residents diagnosed with mental illness that now also suffer dementia?
3. Are care plans person-centered and specific with regard to behavioral triggers and interventions?
4. Is staff skilled in applying behavioral interventions and modification techniques, such as contracting?
5. Is the care of this population consistent and coordinated among members of the clinical team?

As the numbers of younger, mentally ill residents entering the nursing home continue to grow, so will the need to better manage complex psychosocial needs. Similarly, increased numbers of aging residents dually diagnosed with mental illness and dementia will present greater challenges to daily caregiving.

Caring well for this population requires education and skill in creating environments and routines that will reduce the likelihood of extreme emotion and challenging behavior. More than medical intervention, residents with mental illness need psychosocial intervention. Developing programs and services designed to support psychosocial well-being and ensuring those services are coordinated and consistent will help your team to successfully meet the needs of residents with mental illness.

Begin by ensuring your staff has the education and resources to address the many challenges associated with mental illness and dementia. Educational resources can be found on the National Institute of Mental Health website <http://nimh.nih.gov/index.shtml> and on the Alzheimer's Association website www.alz.org. Follow that with the development of standardized systems for assessment, care planning, coordination of services, and a strong quality monitoring process to ensure these systems are maintained.

Helping your staff to better understand the needs and challenges of mental illness will benefit both the caregiver and the resident. Reducing the stress often experienced in the caregiving relationship will not only improve interactions, but will begin the emotional healing these residents need to achieve a true quality of life.

ⁱ Grabowski, Aschbrenner, Rome and Bartels, "Quality of Mental Health Care for Nursing Home Residents: A Literature Review", National Institutes for Health, 2010, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2981653/>

ⁱⁱ Zhang, Gammonley, Paek, Frahm, "Facility Service Environments, Staffing, and Psychosocial Care in Nursing Homes", Centers for Medicare and Medicaid Services, 2008, <https://www.cms.gov/HealthCareFinancingReview/downloads/08Winterpg5.pdf>

ⁱⁱⁱ <http://oig.hhs.gov/oei/reports/oei-05-05-00220.pdf>

^{iv} Dunhan, Charles, "New York State Settles Federal Lawsuit Challenging Placement of Mentally Ill Patients in Nursing Homes", The Health Law Sidebar, 2011, <http://healthlawsidebar.com/?p=566>