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The Reality of the Need and Service of Mental Healthcare in Nursing Homes that Affect the Quality of Care and the Quality of Life

An Evidence-Based Review by Dr. Leo J. Borrell

Part I

2.2012 Forms/Publications/The Reality of the Need Part I

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ABOUT US

Senior PsychCare in affiliation with Senior Psychological Care (SPC) has been a leader in innovative care for stress and age–related problems locally in Houston, the state, and nationally. Making available state-of-the-art and science in psychiatric care in nursing homes and assisted living facilities, **it is our pledge and intent to provide the highest level of psychiatric care to seniors, their families and caregivers.** Understanding these advances may help prevent, control, minimize, or even reverse the number of medical, mental, and adjustment problems that arise in the elderly. We believe the advances in mental healthcare can be of substantial benefit to the number of aging "baby-boomers" **through early diagnosis and treatment, family and social support**. This allows seniors to retain the highest possible level of comfort and functional ability while maintaining their quality of life.

SPC was founded by Dr. Leo Borrell. He founded West Oaks Hospital in the 1970's and Stafford Meadows Substance Abuse Treatment Center in the 1980's. Throughout his career, as a physician and specialized psychiatrist, Dr. Borrell has collaborated with hospital staff, families, and primary care physicians. He has made significant contributions to the community with his teaching and learning together with his involvement at the University of Texas Medical School and Baylor College of Medicine.

SPC is staffed by a team of dedicated professionals with expert knowledge and experience in mental health and geriatric psychiatry. The staff regularly works on an independent basis to provide comprehensive psychiatric services to include evaluation, psychiatric management, and mental health service. Whenever it is appropriate, SPC also works in collaboration with other mental health programs and professionals, including facility medical directors and patient primary care physicians, to provide the very best array of service.

OUR APPROACH

Senior PsychCare in affiliation with Senior Psychological Care utilizes an integrated mental health care plan consistent with Best Practice and the five components of Geriatric Psychiatric Services. The services the company provides include:

- A multi-disciplinary team approach
- Specific geriatric expertise and competence resulting in early diagnosis and treatment which can prevent, control, minimize and even reverse the number of medical problems that can arise in elderly persons resulting in disturbed behavior and deterioration.
- Individualized assessment and treatment planning with routine follow up using standardized outcome measures. After an initial evaluation of the patient, we develop a comprehensive psychiatric program. Frequent evaluation is critical in order to maintain positive results and monitor the patient's response to treatment, as symptoms can frequently fluctuate.
- Collaborative treatment planning between the psychiatric team and the nursing facility staff. The nursing facility staff offers invaluable insight into observed, consistent behavioral changes.
- A strong educational component. Our approach provides an opportunity for integration and collaboration when the nursing home staff or family require the need for more comprehensive treatment and increased intensity of services. This flexibility avoids the fragmentation that often

occurs when the professionals are solo practitioners and do not have the resources of a comprehensive team of medical mental health specialists.

THE PSYCHIATRIC ELEMENT PROGRAM

A psychiatrist and staff provide regular team presence at the care facility, bringing a variety of treatment approaches to increase the quality of life among your residents, reduce your staff's stress and give time needed to manage patients through activities and visibility in the community. This is a vital component in early diagnosis, treatment and prevention. In order to provide optimum care, it is essential to collaborate and receive input from all individuals and professionals who interact with the resident on a daily basis. This also gives recognition for your home to family members and professionals and other caregivers who have a need for referral to a quality nursing home. Our diagnostic plans become a part of the chart available for audits as well as for staff and physicians to review and discuss the ongoing status and resolution regarding recurring or chronic difficulties. We maintain active contact with physicians and staff about psychotropic medications, diagnostic services, psychosocial treatment, and medical and psychological changes in patient status.

There are models for best treatment. First, models that are least effective include those in which a consultant makes a one-time visit when an emergency occurs and simply writes recommendations in a chart consultation without talking to the staff or providing staff education. We know from research that chart recommendations alone are only followed one third of the time (A one-time consultation is problematic with respect to follow-up).

The best treatment is known as "The Integrated Model of Geriatric Psychiatric Care." This plan includes follow-up visits to ensure that prescribed medication or behavioral treatment is implemented appropriately and that the resident is responding without side effects or problems.

Five Components of Geriatric Psychiatric Services Consistent with Best Practices:

1. A multidisciplinary team approach
2. Specific geriatric expertise and competence
3. Individualized assessment and treatment planning with routine follow-up, ideally using standardized outcome measures
4. Collaborative treatment planning between the consultant and the nursing home staff and primary care physician
5. A strong educational component
6. Family involvement

The five components listed above are particularly important with the resident with dementia because the symptoms fluctuate and the medication effects can vary as the dementia progresses. Therefore, it is crucial to detect symptoms early, and increase, decrease or initiate a change of dose in the medication if needed.

We provide a full range of services to assist residents, family members, physicians and staff in recognizing existing and potential problems. We formulate solutions for residents who are mildly depressed or with previous severe psychiatric illnesses, such as bipolar episodes and those who become severely isolated and withdrawn regardless of the cause (whether it is stroke, Alzheimer's, medication

interaction or adverse reactions) which results in marked apathy, comprehensive psychiatric programs for intervention are developed after an evaluation of the resident. This effort involves the family, staff, and primary physician interaction with other mental health professionals. Due to the variety of impaired cognition, we believe and strongly encourage the development of bonding relationships which requires frequent contact as necessary with the resident. In addition, it is essential to collaborate and have input of all individuals and professionals who interact with them to provide optimum care including psychiatric services.

In addition, we take pride in using medications sparingly, conservatively and judiciously that are used in sufficient dosage to gain the desired improvement as well as for extended periods of time to assess the gradual benefit that is often not dramatic. This is confounded by undesired side effects the resident cannot adequately communicate, or changes consistently observed by the staff. **Evaluating the impact of medication frequently is important because there is a tendency to minimize positive results because of disruption or focus on other more severe or pressing medical problems, lack of knowledge, and/or lack of specialized training.** Thus, we provide psychiatric expertise as well as awareness and information on the latest capabilities of the newer psychotropic medication as well as the more specialized role of the older tried and true tranquilizers and sleeping adjuncts.

We are available as a resource to the facility staff when crises arise with residents and families. The medical professional can attend the care plan meetings, offer notes and documentation to substantiate the levels of care needed for residents who are depressed, demented, isolated, delusional, wandering, aggressive, and so forth. Additionally, **we provide the liaison with the resident's family from the home satisfying various quality assurance parameters. We are available to staff and family for training sessions. These are open to the public as a means of enhancing the facility's recognition in the community** (See: "Dementia Care Specialist Training").

PSYCHIATRY, MENTAL HEALTH, QUALITY OF LIFE AND BENEFITS

The Role of the Family – Family Involvement & Family Therapy:

Family Involvement

Residents of nursing homes are referred to SPC for psychological/psychiatric services by the patient's primary care physician. The reason for referral can be due to memory loss, difficulty adjusting to the facility and staff, behavioral issues, depression, anxiety, wandering, delusions, hallucinations, resistance to care, grief/loss issues, etc. SPC provides a full range of services to help residents, family members, physicians and staff recognize existing and potential problems. We formulate solutions for residents who are mildly depressed, those who have had previous severe psychiatric illnesses such as bipolar episodes, and those who have become severely isolated and withdrawn regardless of the cause.

Family members are a crucial part of a successful diagnosis and treatment. Any family input, recommendations, feedback, etc. are very welcome by our staff, and we encourage full participation in family therapy sessions whether or not the patient is involved in the session. Family members' knowledge of the social, behavioral, and emotional habits of the resident can be very helpful to plan treatment objectives and goals. It also helps confirm the underlying reasons for certain behaviors and

other mental health issues. Families can help the therapist explore the patient's feelings and help in finding solutions to problems. Family members know what has and hasn't worked in the past.

More often than not, a family chooses a facility based on input they have received from family members/friends who have had both positive and negative experiences with specific LTC facilities. Family satisfaction with a facility is the most vital determining factor that influences the decision.

Studies show that the below specific areas tend to influence a family's satisfaction:

- The degree of empathy the LTC facility staff demonstrates while providing direct and personal care to a resident, coupled with promptness of care.
- A sense that the LTC facility staff members genuinely listen to the resident's or family members' concerns
- Direct care[1]
- Family-Staff Interaction[1]
- A sense that the LTC facility provide care to the resident in a sensitive, respectful, and timely fashion.
- Accurate and consistent communication between family members and staff. Families feel satisfied when they are permitted to be closely involved in care planning. Scheduling care planning meetings at times when family members are available or allowing an employed family member to participate in the meeting via a conference call during the workday increases the level of a family's satisfaction with a facility.[1]
- The family members' experience when they visit the facility. The satisfaction of family members is often based only on what they see and hear while they are visiting. A facility leader who is aware of that might structure the whole organization so that all staff members are wise to what makes the facility welcoming to the family. SPC can aid the administrator develop and publish a document that clearly outlines what is expected from individual staff members as they interact with family members.[2]

All staff members of the facility (admissions, nursing, activities, therapy, housekeeping, grounds crew) have an impact on how the family feels about the facility. SPC can help an LTC facility make their experience positive.[2] SPC takes pride in educating the resident, the staff, and the family about the patient's diagnosis, medication side effects, aggressive behavior and how to deal with it, memory loss, adjustment problems, etc. We value the opportunity to work with the family. We want the family to choose your facility for their loved one.

The Family Meeting

Family meetings are important for clinicians in order to share information and discuss prognosis and treatments. The goal of the meeting is to establish a forum for communication among the resident, family, and healthcare team so that together they can work to improve the resident's outcome. Effective family meetings also lead to resident and family satisfaction and the development of a plan of care that is consistent with resident and family goals and values.[3]

SPC can provide information about the structure and process of conducting family meetings, and strategies to promote effective family meetings, such as: (1) timing of family meetings; (2) use of a step-by-step process; and (3) communication techniques to support families and facilitate shared decision making.

CARE PLANNING AND BEHAVIORAL ROUNDS

Despite regulations making nursing care planning for residents of long-term care facilities a standard of practice (both as a written document and as part of the interdisciplinary team), its use has not always been valued. Problems arise because nurses do not believe in its efficacy and facilities did little to encourage direct caregivers to become involved in the care-planning process.

However in 2005, the American Health Care Association listed specific federal regulations regarding care plans. Each resident must have a comprehensive assessment. Based on issues identified in the assessment, each resident must have a care plan that has measurable objectives and timetables that meet a resident's medical, nursing, and mental and psychosocial needs.

The care plan is to be used as a communication tool for the interdisciplinary team and should be reviewed and changed periodically as the needs of the resident changes. This process is seen as the basis for which care is received on an individual basis and ensures that quality care is not disrupted. The resident is assessed using resident assessment protocols (RAPs) and by using the Minimum Data Set (MDS). RAPs are used for guidance to address a limited number of clinical issues that are seen in residents of nursing homes.

The interdisciplinary care plan and the written care plan are very different. The interdisciplinary team involves clinicians, residents, and their significant others in the planning process and is continually updated. The written care plan is not updated as often and even though it is expected to, it cannot specify the many issues involved in psychosocial issues. The written plan is limited due to nursing home having few resources, rigid routines, and seemingly endless regulations.

In response to these issues, SPC has developed behavioral rounds to be used as the structure to help synthesize interdisciplinary care planning into the nursing home's routine operations. Behavioral rounds are part of the information gathering, interpreting, and integration of information. The information process is needed in order to obtain goals relating to the quality of care and the quality of life for each resident. Nursing home staff, residents, and the resident's significant others all benefit from the development of strategies that are effective in synthesizing interdisciplinary care planning into the nursing home's operations.

TRANSITIONS OF CARE

Admission and discharge to and from nursing homes is a critical issue since it results often in miscommunication and inappropriate care. SPC has developed special programs to minimize these problems and reduce avoidable hospitalization and adjustment problems on admission. Nursing home staff communicate with a variety of medical doctors on a routine basis. Appropriate care for the resident requires accurate communication with the resident's physician. The following guidelines were developed to assist in the nursing staff/physician communication.

(*for additional information, see articles*:

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EVIDENCE-BASED REDUCTION OF NEED FOR PSYCHIATRIC HOSPITALIZATION DUE TO PSYCHOTHERAPY

Recent research has demonstrated that the intensity of a psychotherapy intervention program **(1-3 times per week and involvement of the family)** significantly reduces the chance of psychiatric hospitalization and intensity should determine the extent of psychosocial intervention (e.g., psychotherapy). In addition to screening for depression, the decision for intensity of therapy should be left in the hands of mental health professionals rather than the medical care team and intensity of therapy should not be left completely in the hands of medical care professionals.[1] The best patient predictors for psychiatric hospitalization are noted as severity of dementia and behavioral problems and interestingly, the research did see evidence that caregiver depression and the caregiver's sense of competence in caring for the patient are equal and additional predictors for psychiatric hospitalization. Furthermore, the intensity of the psychotherapy intervention should be standardized and be dependent upon the judgment of the mental health professionals and not the health care team or primary care physician. **This research supports that standardized-intensive psychotherapy for both the patient and the family is essential and distinguishes effective programs from ineffective ones with no difference being noted between children or spouses of patients as caregivers. Both groups benefit from therapy and help to reduce the need for patient psychiatric hospitalization.**

In summary, the best approach is to treat the whole person. Thus, care is provided in a sensitive manner taking into consideration the advances and knowledge of biological, social and psychological components for the elderly to obtain optimum care.

Dementia in nursing home residents was 58% whereas the prevalence of behavioral and psychological symptoms of dementia (BPSD) was 78%. Major depressive disorder had a median prevalence of 10%, and the median prevalence was 29% for depressive symptoms. Minimum data set results reveal that 46.5% have dementia, 47% have depression, 30% show behavioral symptoms, 3% have mental retardation, and 20% have other psychiatric disorders.

To what extent has the field of geriatric psychology improved since the introduction of the US Omnibus and Reconciliation Act of 1987 (OBRA 87)? We are more vigilant and appropriately cautious about the use both of physical restraints and of psychotropic medications, we still have quite a way to go. Diagnostic clarification and psychopharmacology is the dominant intervention offered by psychiatrists. This narrow emphasis is not serving the nursing home population adequately. **The available antidementia compounds, cholinesterase inhibitors and memantine, do have demonstrable, but limited impact on relieving BPSD.**

Geriatric psychiatrists will be offering inadequate clinical value in the nursing home if the psychotropic medications currently available are not safe and are not sufficiently effective. Ninety-seven percent of residents were experiencing at least one symptom. Agitated behaviors were especially persistent and apathy tended to increase over time, although there was a decrease in affective symptoms. Early identification of depression is of great importance to the well-being of nursing home residents. Mitchell

et al[3]. from the United Kingdom report on a meta-analysis of the diagnostic accuracy of different versions of the Geriatric Depression Scale[3]. Screening programs in nursing homes must be adequately resourced so that their clinical utility can be property evaluated and demonstrated[4].

Stevenson and colleagues[5] noted that 26% of residents were prescribed an antipsychotic medication. Of particular concern was the finding that 40% of those receiving an antipsychotic had no documented appropriate indication for such use. Among the 13% of residents who received a benzodiazepine, 42% had no appropriate indication identified.

In this situation, the specific contributors to the display of mental illness in the nursing home are: the physical environment, the processes of case, and the behavior of people (care providers and other residents). Literature on environmental design concluded that there is sufficient evidence accumulated to come to a consensus on guiding principles for the design of long-term care environments for people with dementia that maximize function and mental well-being. The use of single rooms, unobtrusive safety measures, varied ambience, and controlled levels of stimulation are all supported by the literature as useful interventions. There is less agreement on the usefulness of other interventions (e.g., enhanced signage, homelikeness, provision for engagement in activities of daily living, small size, and access to outside space).

PSYCHIATRIC AND PSYCHOTHERAPY ECONOMIC CONSIDERATIONS

A study by O'Brien and Caro[2] compared management levels and the annual costs of caring for nursing home residents with and without AD or other dementia. In this study of 49,724 nursing home residents, 26.4% had a documented diagnosis of dementia. Each of these patients required, on average, an additional 229 hours of care annually compared with residents without dementia, **resulting in a mean additional cost of $3,865 per patient with dementia per year in 1997 dollars. In 2005 dollars, this would translated to approximately $4,700 per patient per year.** [3]

Problem behaviors add costs to long-term care. Physical agitation, care refusal, and requests for attention were among the most frequently observed problem behaviors in a study of AD patients in long-term care settings.[3] Management strategies for these behaviors typically took one or more nursing staff an **estimated 5 to 20 minutes to put into practice, at a cost of $1.35 to $4.09 per episode (2000 dollars; $1.53 to $4.62 inflated to 2005 dollars**).

SEVERE PSYCHIATRIC ILLNESSES

The factors that contribute to the high cost of mental healthcare with patients with severe psychiatric problems (schizophrenia and bi-polar illnesses) are:

- Increased use of mental healthcare services (including inpatient, outpatient, and medication treatments)
- Combination of treating psychiatric and substance abuse disorders
- Increased use of emergency room services
- Higher occurrences of medication nonadherence

REDUCING PSYCHOTROPIC DRUG USE IS EASY: EVIDENCE-BASED MEDICINE

Dr. Rosenblatt's[1] research shows about treatment of depression and dementia:

1. 51% of participants with dementia and depression did improve their quality of life.
2. 58% of those with depression alone, receiving the comprehensive intervention had recovered from their depression six months alter and had a better quality of life.
3. Only 25% of those receiving unsupplemented general practitioner care decreased depression, but they did not have significantly better quality of life.
4. 25% died in the first two years. Patients need to be seen 1-4 times per month in order to monitor the constant fluctuation of behavioral and psychiatric symptoms and medical problems.
5. Post-stroke depression usually resolves in 6 months but can last two years.

Without psychotherapy, individuals with depression or dementia or both:

- 20% continued to exhibit behavioral symptoms[1].
- 40% exhibited physically and/or verbally aggressive behavior[1].

The Role of Psychotropic Medications

Over the years, medications have been developed that can improve the lives of individuals with infections, high blood pressure, diabetes, gastro-intestinal disorders, allergies, and other physical ailments. Additionally, medications have been developed to assist in managing care for those afflicted with mental health issues. Questions about the efficacy of medications targeted for mental health management have been raised and some medications have been found to fall short of their targeted goal. **In fact there is evidence that the way antidepressants are currently being administered to nursing home patients renders the medication ineffective.[3] A recent study shows that elderly adults would prefer psychotherapy over medication as their treatment of choice for depression.[3]**

The question that should be raised is regarding patient care. "Is the patient better? Are the symptoms reduced, or have they remitted? Is there general improvement in the patient's level of functioning?" [2] A problem to consider is not the medication itself but who is prescribing the psychiatric medications. Many primary care physicians are now prescribing antidepressants yet are only adding 3-4 minutes to the patient's medical visit for assessing mental health[2]. This added time barely allows for symptom management and follow-up on functionality/effectiveness of the medication prescribed. With limited patient contact, there is also the risk of overmedication and troubling side effects.

A variety of psychotherapies including cognitive-behavioral therapy and behavior modification strategies work well for seniors with depression, anxiety, panic disorders, behavioral issues associated with psychological issues, PTSD, obsessive compulsive disorders, and insomnia[2]. However, prescribing medications for a specific disorder should not be seen as an automatic response but as an individualized process[2]. Each patient must be thoroughly assessed, physical issues considered, and continually monitored.

Evidence-based Psychotherapy

There are some limitations of psychotherapists to provide services. Mental health professionals may also have biases towards providing care for seniors which could limit the quality of care and quality of

life for the elderly. Some mental healthcare providers believe that medications alone are the only treatment. Now research shows that therapy is more effective than medications alone.

Patients who received psychotherapy (counseling) did 100% better than those that received medication alone[1]. They also had a significant decrease in behavioral problems sooner and a better quality of life for longer[1]. Early evaluation and accurate comprehensive diagnosis is necessary. Medications alone are not enough. A comprehensive plan of 6-24 months with counseling is necessary to maximize results, prevent relapse, and improve quality of life.

SPC provides continual training to our mental health providers because not all psychologists and psychiatrists are experienced in providing care for seniors. SPC continues to update our training with the latest research which enables our mental health professionals to not only be aware of various therapies but understand how to use them to provide quality care.

PSYCHOTHERAPIES
DIFFERENT STROKES FOR DIFFERENT FOLKS

	Focus of Intervention	Specific Techniques
Cognitive-Behavioral Therapy (CBT)	Maladaptive thoughts and behaviors	Self-monitoring, increasing participation in pleasant events, challenging negative thoughts and assumptions
Interpersonal Therapy (IPT)	Unresolved grief, interpersonal disputes, role transitions, skills deficits	Exploration of affect, behavior change techniques, reality testing of perceptions
Problem-Solving Therapy (PST)	Problem-solving skills	Identifying specific problems; brainstorming, evaluating, implementing and reviewing solutions
Brief Psychodynamic Therapy	Lack of insight, relationship problems	Analyzing current problems in light of historical patterns, using the therapeutic relationship to identify issues and practice new ways of relating to others.
Life Review	Integration of past and present experiences	Structures reminiscence, constructive reappraisal of the past, recollection of previously used coping strategies
Dialectical Behavior Therapy (DBT)	Negative affect, impulsivity, suicidal thoughts and gestures, interpersonal skills deficits	Increasing mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness skills
Family Therapy	Past and current family issues	Psychoeducation of patient and family, assessment of relationship difficulties, behavioral prescriptions
Caregiver Interventions	Stress and burden	Emotional support, encouragement of help-seeking and self-care, information about community resources, may include CBT and PST elements

PSYCHOSOCIAL INTERVENTIONS

Psychosocial treatments for anxiety should be considered viable, safe alternatives to medications in patients with dementia although, again, research is limited. Outcome data on cognitive-behavioral therapy (CBT) for anxiety in dementia have shown promising results in several case studies. Successful CBT in these patients relies on strategies to circumvent cognitive limitations in learning and applying new coping tools. These include simplifying skill training, repetition, and recruiting collaterals (eg,caregivers) to act as coaches.

Other non-drug interventions that show promising results in case series or small pilot studies include milieu therapy, addressing patients' specific environmental needs, and caregiver psychoeducation.

GROUP THERAPY FOR DEMENTIA PATIENTS

The increase in the early detection and diagnosis of Alzheimer's disease has resulted in a growing population of patients with relatively intact insight and expressive skills. There is a scarcity of related literature addressing the supportive needs of diagnosed patients.

The work of psychiatrist Irving Yalom is widely recognized for therapeutic factors in group work. In 1991 Yale confirmed the applicability of these factors to group process with Alzheimer's patients. In her research with these groups, Yale observed that patients became cohesive very quickly. They were able to discuss a variety of topics that resulted in expressing understanding and knowledge about Alzheimer's disease.

Shoham and Neuschatz also conducted group therapy with patients. They reported that the use of structured topics in their groups helped patients stay focused. Closser and Wexler evaluated groups on a scale of "helpfulness." Their findings indicated that learning about how others are dealing with their problems, sharing feelings with other groups members (including anger, bitterness, and guilt) scored highest. Learning practical solutions to everyday problems ranked high on the scale of helpfulness in their caregiver groups. The structured topics advocated by Shoham and Neuschatz were an asset in this study for keeping the thought processes focused, especially for those patients at the more moderately impaired end of the criterion range for acceptance in the project.

SERVICES SPC OFFERS TO LONG-TERM FACILITIES

- **Behavioral Medical Rounds**: to review all patients with cognitive impairment and emotional problems, behavioral problems, and prevent F-Tags
- **Community Education**, Public Relations, Caregiver Support
- **Consultation For Quality Improvement**, Cultural Change, Psychotropic Medication Reduction, and Team Section and Team Building, Coaching and Mentoring, Addressing Medicare Mental Healthcare Survey Issues including but not limited to F-Tags 328, 429 and 501
- **Coordination of Care** with primary care physician and medical director, and attending quality care meeting
- **Dementia Care Training for staff**
- **Family Education** Support Groups **Psychotherapy Counseling**: Individual, Group, and Family Therapy
- **Management Consultation – Team Building** and Selection
- **Psychiatric Diagnosis and Evaluation:** Treatment Planning, Neurologist Interview, Borrell Cognitive Neuropsychiatric Inventory (BCNI) – Mental Health Screening for Dementia, Mini – Mental Status Examination (MMSE), Depression and Anxiety, In service Training for Nurses and CNA, Assistance with Psychiatric Hospitalization and Partial Hospitalization and Intensive Outpatient Programs; MDS Consultations
- **Psychiatric Evaluation and Psychotropic Medication Management**: Consultation for management of dementia and related problems - depression, anxiety, psychosis, and behavioral problems
- **Rapid Response** teams for management behavioral problems
- **Responding to State Surveyor's Concerns** about mental healthcare and policy regarding medications, F-Tags and Gradual Dose Reduction
- **Screening of All Patients:** standardized and computerized tests to determine types of dementia and areas of memory impairment that allow more appropriate psychological, psychiatric, and nursing staff intervention. This allows the assessment of the progress of treatment of cognitive and emotional function.
- **Telemedicine** for SNF patients and staff communication
- **Training of Mental Health Professional**: Supervision for LCSW certification, Special Skills and Techniques for Psychotherapy with seniors. CE for Social Workers, Psychologist MD, NP/PA – a complement to care planning and the quality improvement program.
- **Transition of Care Program: Focus on Admission and Discharge of Patients to Minimize Adjustment Problems and Rehospitalizations.**
- **Triage and Facilitation** for psychiatric hospitalization

NEW FOR 2012:

- **2012 – Special education programs** for professionals and nursing home staff:
  - Dementia Care
  - Motivational Interviewing for resistance to care
  - Training and Depression Treatment Using Behavior Interventions
  - Validation and Reminiscence therapy for moderate to severe dementia
- **Training and Depression Treatment Using Behavior Intervention**
- **2012 – Transitioning of care** for prevention of re-hospitalization of SNF patients.
- **2012 – Video-conferencing with families, nursing-home staff, and the primary care physician.** The improvement of communication and coordination of relationship care is directly related to the resident's quality of care and quality of life.

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Education

Undergraduate-Emory University, Atlanta, Georgia
M.D. – Emory University School of Medicine
Harvard Medical School Fellow in Adult Psychiatry
Sheppard-Pratt Residency in Adult Psychiatry

Specialty Certification

Certified in Addictionology, 1989
American Society of Alcoholism and Other Addictions
Certified in General Psychiatry, 1981
American Board of Psychiatry and Neurology

Professional Awards

Distinguished Fellow & Fellow – American Psychiatry Association, 2004
Wendell-Muncie Award, 1974, Maryland Psychiatric Society

Present Professional Responsibilities

Private Practice, Adult Psychiatry since 1975 - Present
Member, Medical Advisory Board, Health Help Network
Member, American Geriatric Psychiatry Society

Past Professional Responsibilities

Board of Directors, DRCA Medical Corporations, 1992-94
Founding/Managing Partner, Stafford Meadows Hospital
Founder/Chairman, Psychiatric Services of Houston
Medical Director of Day Hospital, Short and Long Term Treatment Units
Psychiatric Consultant, Houstonian Medical Specialist
Founder of West Oaks and Stafford Meadows Hospitals
Medical Consultant Well Woman's Clinic

Select Publications/Presentations

"Thyroid Eye Disease and Psychiatry"
Prospective on Ophthalmology, September 1980
"The Psychiatrically Hospitalized Physician"
Texas Medicine, August 1981
"Technology Trends in Home Health Care"
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Assisted Living Consult Magazine, September/October 2006

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The State of Mental Healthcare in Nursing Homes

A Review by Dr. Leo J. Borrell

Studies over the past twenty years have recognized the pervasiveness of mental illness among residents of nursing homes. Dementia, behavioral and psychological symptoms of dementia (BPSD), and depression characterize the resident population. Seitz and colleagues[1] reported on the prevalence of major psychiatric disorder in long-term care derived from a number of carefully screened epidemiological studies. **Dementia in nursing home residents was 58% whereas the prevalence of BPSD was 78%.** Major depressive disorder had a median prevalence of 10%, and the median prevalence was 29% for depressive symptoms. Minimum data set results reveal that 46.5% have dementia, 47% have depression, 30% show behavioral symptoms, 3% have mental retardation, and 20% have other psychiatric disorders. Nursing home residents are becoming bewilderingly more complex than in the past and more difficult to address[2]. It is incumbent to comprehensively assess our readiness to meet this substantial challenge.

To what extent has the field of geriatric psychology improved since the introduction of the US Omnibus and Reconciliation Act of 1987 (OBRA 87)? We are more vigilant and appropriately cautious about the use both of physical restraints and of psychotropic medications, we still have quite a way to go. Diagnostic clarification and psychopharmacology is the dominant intervention offered by psychiatrists. This narrow emphasis is not serving the nursing home population adequately. **The available antidementia compounds, cholinesterase inhibitors and memantine, do have demonstrable, but limited impact on relieving BPSD.**

Geriatric psychiatrists will be offering inadequate clinical value in the nursing home if the psychotropic medications currently available are not safe and are not sufficiently effective. Ninety-seven percent of residents were experiencing at least one symptom. Agitated behaviors were especially persistent and apathy tended to increase over time, although there was a decrease in affective symptoms. Early identification of depression is of great importance to the well-being of nursing home residents. Mitchell et al[3]. from the United Kingdom report on a meta-analysis of the diagnostic accuracy of different versions of the Geriatric Depression Scale[3]. Screening programs in nursing homes must be adequately resourced so that their clinical utility can be property evaluated and demonstrated[4].

Stevenson and colleagues[5] noted that 26% of residents were prescribed an antipsychotic medication. Of particular concern was the finding that 40% of those receiving an antipsychotic had no documented appropriate indication for such use. Among the 13% of residents who received a benzodiazepine, 42% had no appropriate indication identified.

In this situation, the specific contributors to the display of mental illness in the nursing home are: the physical environment, the processes of case, and the behavior of people (care providers and other residents). Literature on environmental design concluded that there is sufficient evidence accumulated to come to a consensus on guiding principles for the design of long-term care environments for people with dementia that maximize function and mental well-being. The use of single rooms, unobtrusive safety measures, varied ambience, and controlled levels of stimulation are all supported by the literature as useful interventions. There is less agreement on the usefulness of other interventions (e.g., enhanced signage, homelikeness, provision for engagement in activities of dialing living, small size, and access to outside space).

Over the past two decades, research has examined nonpharmacologic interventions that benefit nursing home residents with dementia. A recent review of psychosocial interventions in dementia care specific to nursing homes concluded that **the most effective interventions utilized behavior management techniques, cognitive stimulation, or physical activity interventions. Evidence also supports psychotherapies such as reminiscence and cognitive behavior therapies for residents with symptoms of depression and other related symptoms**[6].

The mental health of nursing home residents can be enhanced in an environment offering high-quality medical care guided by some basic principles of ensuring well-being[7]. Various models of psychogeriatric services in nursing homes reported on nine controlled trials and concluded that liaison-style services that employed educational approaches, treatment guidelines, and ongoing involvement of mental health staff are more effective than a purely case-based consultation model[8]. Snowdon[9] recently described a variety of models of mental health service provision including solo practitioners. The value of consultation via interactive videoconferencing, particularly for nursing homes located in remote areas and for nations that limit funding for residential care, was also highlighted. Recommendations are provided that include adequate screening for mental illness, designation of staff members who take responsibility for identification, and, if necessary, referral to a mental health specialist. **Active involvement of the primary care physician and effective liaison between the facility and mental health teams is a required essential feature. A number of reports have highlighted the benefits of having nurse specialists provide significant frontline consultation and care**[10,11]. Moyle et al. have recently reviewed the literature on this topic and made a series of useful recommendations[12]. They are as follows:

1. **Nursing homes should have an established staff development program** related to resident mental healthcare needs.
2. **Prior training in mental healthcare should be a key selection factor** when hiring new staff.
3. **A process of staff evaluation should be in place** and homes should facilitate staff attendance at education and training sessions.
4. **A reward system should be in place for staff** who undertake educational programs. It is also particularly important to support unregulated staff to achieve competency in the mental healthcare needs of older individuals.
5. **Curriculum designers must take into account the special** needs and schedules of LTC staff.

Psychiatric and Psychotherapy Economic Considerations

A study by O'Brien and Caro[1] compared management levels and the annual costs of caring for nursing home residents with and without AD or other dementia. In this study of 49,724 nursing home residents, 26.4% had a documented diagnosis of dementia. Each of these patients required, on average, an additional 229 hours of care annually compared with residents without dementia, resulting in a mean additional cost of $3,865 per patient with dementia per year in 1997 dollars. In 2005 dollars, this would translated to approximately $4,700 per patient per year. [2]

Problem behaviors add costs to long-term care. Physical agitation, care refusal, and requests for attention were among the most frequently observed problem behaviors in a study of AD patients in long-term care settings.[3] Management strategies for these behaviors typically took one or more nursing staff an **estimated 5 to 20 minutes to put into practice, at a cost of $1.35 to $4.09 per episode (2000 dollars; $1.53 to $4.62 inflated to 2005 dollars**). Behavioral problems have been specifically measured in some studies with donepezil[4-6] and rivastigmine.[7] These studies show that treatment has a positive impact on measures of behavior. Because behavior problems are costly, cholinesterase inhibitors may reduce the cost of handling problem behaviors in long-term care. In fact, discontinuing

cholinesterase inhibitor treatment is associated with a significant increase in daily labor costs. Nursing home residents who discontinued the medication incurred a mean daily labor cost of $55.16 compared with $49.60 at baseline. Patients who continued donepezil incurred a mean of $6.90 less per day than patients who discontinued.[8]

A 2004 article on the use and cost benefits of cholinesterase inhibitors in long-term care reviewed both cost-saving and cost-effectiveness data.[9] The authors concluded that given the cost of drug therapy, the difficulty in correlating cognition and behavioral scoring tools with disease severity, and the applicability of community costs prior to nursing home care, the results of the current data are equivocal at best. However, there is the real consideration of resident quality of life, maintained independence, and nursing home caregiver burden; which all need to be studied in some manner.

Severe Psychiatric Disorders, Cognitive Impairment, and Mental Healthcare Costs

A 2005 study states the costs for treatment of psychiatric illness is at over 47 billion dollars per year. The factors that contribute to the high cost of mental healthcare are:

- Increased use of mental healthcare services (including inpatient, outpatient, and medication treatments)
- Combination of treating psychiatric and substance abuse disorders
- Increased use of emergency room services
- Higher occurrences of medication nonadherence

The 2005 study did not address cognitive impairment as an additional factor for increased mental healthcare costs. A valid assessment of cognitive impairment is the *Mattis Dementia Rating Scale-Second Edition* and the *Clinical Dementia Rating* is used to assess stages of dementia in seniors with cognitive impairment.

The source study published in February 2011 specifically researched the impact of cognitive impairment on costs and concluded that seniors with cognitive impairment who also have a diagnosis of a severe psychiatric disorder are a significant factor for rising mental healthcare costs. A 6-month study on mental healthcare costs comparing young schizophrenic patients to the cognitively impaired elderly suggests that costs for the young patient group was **significantly higher at $23,824 than the elderly group at $8,145 due to more intensive, inpatient, specialized treatment for severe psychiatric problems such as schizophrenia and bipolar disorder**. However, one limitation of the study is lack of access to the cost of medications during treatment which is believed to be a considerable factor in mental healthcare costs.

The degree to which specific therapies for those with cognitive impairment may reduce costs requires more detailed research. Past research have shown that the cognitively impaired patient did benefit from mental healthcare and found that costs can be mitigated if the individual receives tailored intensive mental health treatment. **While intensive treatment is more costly short-term, the improvement of the patients suggests a reduction in long-term mental healthcare therefore reducing overall costs**.

Evidence-based Reduction of Need for Psychiatric Hospitalization due to Psychotherapy

Recent research has demonstrated that the intensity of a mental healthcare intervention program significantly reduces the chance of psychiatric hospitalization, **intensity should determine the extent of psychosocial intervention (e.g., psychotherapy), and intensity of therapy should not be left**

completely in the hands of medical care professionals (Spijker, et al. 2011). The best patient predictors for psychiatric hospitalization are noted as severity of dementia and behavioral problems. Interestingly, the research did see evidence that caregiver depression and the caregiver's sense of competence in caring for the patient are equal and additional predictors for psychiatric hospitalization. **Furthermore, the intensity of the psychotherapy intervention should be standardized and not be dependent upon the judgment of health professionals. This research supports that standardized-intensive psychotherapy for both the patient and the family is essential and distinguishes effective programs from ineffective ones with no difference being noted between children or spouses of patients as caregivers. Both groups benefit from therapy and help to reduce the need for patient psychiatric hospitalization. (Spijker, et al. 2011)**

Depression

Depression affects 20% to 32% of persons with dementia and the prevalence is higher in patients with vascular dementia than in patients with Alzheimer's disease (AD). Assessing depression in dementia patients poses several challenges. Depressive symptoms can be the initial manifestations of dementia and may fluctuate over time. Compared with older patients with intact cognition, patients with dementia are more likely to report a diminished ability to concentrate or indecisiveness during a major depressive episode. On the other hand, patients with dementia are less likely to report insomnia/hypersomnia, feelings of worthlessness and guilt, or thoughts of death/suicide.

Further confounders of assessment include symptoms of apathy and anxiety. These symptoms frequently coexist with depression but are also independent behavioral dimensions.

- <u>Depression Screening</u>
  How often within the past two weeks have any of the following problems bothered you?
  (scale: 0=not at all, 1=several days, 2=more than 1 week, 3=almost two weeks)

➢ Had little interest or pleasure in doing things	0	1	2	3
➢ Felt down, hopeless, or depressed	0	1	2	3
➢ Had trouble falling or staying asleep or slept too much	0	1	2	3
➢ Felt tired or had little energy	0	1	2	3
➢ Little appetite or overate	0	1	2	3
➢ Felt bad about self, felt like a failure, or Felt like you let self or family down	0	1	2	3
➢ Had trouble focusing (trouble reading newspaper or watching television)	0	1	2	3
➢ Others noticed you moved or spoke slower than usual or were more fidgety/restless than usual	0	1	2	3
➢ Felt that you or loved ones would be better off if you were dead	0	1	2	3
➢ Had thoughts of hurting self in some way	0	1	2	3

  If you checked off any problems, how have these problems affected your daily life (work, taking care of self/home, or relationships with others)?
  ☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

- <u>Treatment of Depression</u>
  A variety of approaches can be used to treat depression in patients with dementia. These include electroconvulsive therapy (ECT), pharmacotherapy, and psychosocial modalities.

Psychosocial modalities. Nonpharmacological interventions include supportive-therapy techniques, such as reminding the patient of earlier accomplishments, focusing on positive aspects of life, instilling hope, and promoting enjoyable recreational activities. Of 11 randomized controlled studies of psychosocial treatments of depression in older adults with dementia, 7 showed significant improvement in the treatment group compared with the control group. In 6 of these studies, improvements were maintained beyond the active treatment.

The psychosocial treatments studied were diverse. They included interventions based on behavioral approaches that focus on training caregivers to problem-solve and communicate effectively. Structured programs were used to increase social engagement, and interventions were employed to modify sensory or environmental stimulation. Group reminiscence therapy also improved cognitive and affective function in a recent randomized controlled trial undertaken by Wang.

Typical psychological interventions were based on the traditional one-on-one psychotherapy model[2]. Researchers propose that intervention be based on an integrative-behavioral model of depression utilizing a collaborative relationship between mental health professionals and the members of the activities staff (research assistants and other outside consultants for implementation may also be useful)[2]. Chose participants who are: not terminally ill, not already in psychotherapy, not under hospice care, who are medically stable, have a Mini-Mental State Examination score of > than 13, and/or have a Geriatric Depression Scale score of 11 or greater[2]. You may find that consenting participants may not actually benefit from the intervention due to depression rating scores being too low or their cognitive impairment is too severe. The phases of the intervention are: baseline assessment (may last 2 – 4 weeks), active treatment (6 weeks), treatment maintenance (4 weeks), and follow up is at week 24[2].

Researchers Meeks, Looney, Van Haitsma and Teri[2] developed an intervention manual with changes made to allow a more realistic allotment of session time between the NH staff and mental health professionals who became responsible for scheduling treatment sessions. The manual also contains a list of "Pleasant events" and were recorded on a "Pleasant events" scale which is reviewed each session[2]. During nursing home staff meetings, it was noticed that the majority of the meeting involved discussing barriers to pleasant events with little time needed reviewing behavioral problem issues[2].

The researchers found the nursing home staff members (3 were in social services and 4 were in the activities department) eager to follow the "Treatment Session Content" (see table below), but staff were restricted due to lack of time and resources[2]. The collaboration between staff and therapist necessitated the therapist demonstrating empathy for the staff and assisting in problem-solving around the barriers. Nursing home staff did recognize the value of the manual's ability to help structure tasks and visualize client progress[2]. Participation in the activities increased when obstacles decreased (ineffective communication resulting in residents not ready for activities, lack of supplies, and staff using ineffective methods such as nagging to prompt residents to participate)[2]. Although the nursing home staff were aware of these barriers, the empathic support of the therapist was needed to overcome these obstacles[2].

Depression symptoms were monitored during the treatment sessions and the results showed a clinically significant reduction in symptoms with a 75% recovery rate at follow-up (vs. 50% for control group)[2]. The treatment group did receive more attention for the therapist than the control group and this cannot be ruled out as a confounding variable making it indistinguishable to

determine if increased attention or increased activities caused the decrease in depression symptoms[2].

The treatment session in the below table represents an approach to depression intervention in long-term care that does not solely rely on education, training, or the use of external mental health professionals[3]. It does require the collaboration between nursing home staff and trained mental health professionals and has the potential to increase staff satisfaction, be widely used, and improve the quality of life for residents[2].

Treatment Session Content[2]

"Session	Content
1st	**Introduction to Behavioral Therapy for Depression**: Introductions, review research procedures. Explain relationship between pleasant events and mood, relevance for depression. Assess pleasant events. Plan three events that are easily accomplished. Identify relevant family members to be involved, if appropriate. ASF present with therapist and resident.
2nd	**Scheduling Pleasant Events and Encouraging Family Involvement**: Focus is planning further pleasant events. Last week's events are reviewed. Therapist reinforces resident for accomplishments and effort. If family member is present, discuss how he or she can be involved in further implementing pleasant events. Plan events for coming week.
3rd	**Confronting Obstacles**: The focus is on obstacles to achieving desired events. The A-B-C behavioral method is used to understand obstacles and, if necessary, develop a behavior plan to overcome them. Therapist reinforces resident (and family member if present) for effort. Last week's events are reviewed and new events planned for the next week.
4th	**Increasing Pleasant Events**: The goal of this session is to continue to increase pleasant events that are feasible for staff and residents, and include family members when possible. Obstacles are confronted and problem-solving focuses on changing them. A goal of 6-8 pleasant events is optimal, but individual differences are taken into consideration.
5th	**Assessing Progress/Choice Point**: ASF is included in this session. Goal is reevaluation and checking; resident and therapist review progress with staff (and family if present). If the resident is involved in five new events weekly, then future sessions will focus on increasing and/or maintaining activity level. If the resident is still struggling to find feasible events, the focus on the next few sessions is eliminating barriers.
6th-9th	**Maintaining Gains, Problem Solving**: Goals depend on decisions during Session 5. Problem solving continues as necessary. During these weeks, the activities staff develops an ongoing plan that will be integrated into the resident's care plan. The staff members and resident learn about the possibility of relapse and other factors that could make activity level decline in the future, and develop plans for coping with such setbacks. Staff members may participate, and even take the lead, in some sessions, supported by the therapist.
10th	**Summing Up**: ASF is present for this session. Progress is reviewed. Plans for the future are discussed and summarized, including how staff will help resident continue activity levels and how staff, resident, and family will cope with changes in future. Resident, staff, and family are reinforced for effort and progress.

Note: ASF=activity staff facilitator: A-B-C=antecedent-behavior-consequence."[2]

(See also: Broekman BFP, Niti M, Nyunt MSZ, Ko SM, Kumar R, & Ng TP. Validation of a brief seven-item response bias-free geriatric depression scale. *Am J Geriatr Psychiatry* 2011;19[6]:589-596).

Anxiety

Community prevalence of anxiety in patients with dementia is nearly 20%. Generalized anxiety disorder (GAD), one of the most frequently diagnosed anxiety disorders in later life, occurs in 5% of patients with AD. Estimates of clinically significant anxiety are as high as 70% depending on the clinical sample (higher for vascular and frontotemporal dementias) and screening modality (lower in studies that employed structured clinical interviews).

As with depression, the assessment of anxiety disorders in individuals with dementia is challenging. First, geriatric patients tend to underreport psychological problems and overemphasize somatic complaints. Another issue is the high comorbidity of anxiety with major depression in AD (more than 75%): this statistic raises the question of whether AD is independent from, or an epiphenomenon of, depression.

- Treatment of anxiety

  Although pharmacological interventions are most frequently employed, no randomized clinical trials have evaluated the use of medication for treating anxiety disorders in persons with dementia. Thus, all recommendations for drug therapy must be cautiously interpreted.

Psychosis

Psychotic symptoms of delusions and hallucinations have been shown to be present in 18% and l4%, respectively, of patients with dementia in a community-based cohort, and it is higher in LTC patients. Considerably higher estimates are often quoted in clinical samples, especially in patients with Lewy body dementia.

Agitation/Aggression

Among individuals with dementia in the community, 27% exhibit agitation/aggression. The prevalence increases as dementia progresses (13% in mild dementia; 24% in moderate dementia; and 29% in severe dementia).

- Treatment of Agitation/Aggression

  Therapy for agitation/aggression

  The effectiveness and safety concerns of medication use, especially antipsychotics, argue for greater emphasis on nonpharmacological interventions in treating behavioral disturbances.

  Behavioral approaches

  A systematic "ABC" approach to implementing a behavioral plan helps individualize treatment and monitor improvement.

  Antidepressants (SSRIs and hazodone) have not been well studied for symptoms other than depression, although their relative safety profile may warrant a therapeutic trial, especially for nonpsychotic patients with mild agitation. Results from a small, randomized, clinical trial with trazodone showed promising results for decreasing problematic behaviors in patients with frontotemporal dementia.

  There is also evidence of modest, but statistically significant, efficacy of cholinesterase inhibitors. There is limited evidence of efficacy for anticonvulsants, lithium (Drug information on lithium), and

alpha-blockers. All these agents can cause significant adverse effects and thus are not recommended, except for patients who have not responded to other treatments.

Conclusion

Psychiatric comorbidity in persons with dementia reflects phenomenology and diagnostic treatment challenges that are distinct from those in elderly, cognitively intact individuals with psychiatric illness. To date, large systematic reviews of available pharmacological treatments highlight their lack of efficacy and increased adverse effects.

Given the rising incidence of dementia, the ubiquitous nature of associated neuropsychiatric disturbances, limits of current pharmacological treatments, and modest effect of pharmacological and nonpharmacological interventions, the clinical judgment of the psychiatrist and psychotherapist are the best that can be done.

Articles:

- **A Review by Dr. Leo J. Borrell**
  - (Source: Reichman WE, & Conn DK: Nursing Home Psychiatry: Is it Time for A Reappraisal? *Am J Geriatr Psychiatry* 2010;18(12):1049-1053)
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- **Psychiatric and Psychotherapy Economic Considerations**
  - Source: Bright-Long, L. Alzheimer's treatment in nursing homes: Room for improvement. *JAMDA* 2005;09.
  - See also: Vernooij-Dassen M, et al. Focus on mental health issues in long-term care homes. Psychocial interventions for dementia patients in long-term care. International Psychogeriatrics (2010), 22:1121-1128 *Cambridge Journals*
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- **Severe Psychiatric Disorders, Cognitive Impairment, and Mental Healthcare Costs**
  - (Source: Macklin RS, Delucchi KL, Bennett RW, & Arean PA. The Effect of Cognitive Impairment on Mental Healthcare Costs for Individuals with Severe Psychiatric Illness. *Am J Geriatr Psychiatry.* 2011;19[2]:176-184)

- **Evidence-based Reduction of Need for Psychiatric Hospitalization due to Psychotherapy**
  - (Summarized by Dr. Borrell. Source: Spijker A, Wollersheim H, Teerenstra S et al. Systematic care for caregivers of patients with dementia: A multicenter, cluster-randomized, controlled trial. *Am J Geriatr Psychiatry* 2011;19(6):21-31)

- **Depression, Treatment of Depression, Anxiety, Psychosis, Agitation/Agression**

1. (Source: King-Kallimanis MS, Gum AM, & Kohn R. Comorbidity of depressive and anxiety disorders for older Americans in the National Comorbidity Survey-Replication. *Am J Geriatr Psychiatry* 2009;17(9):782-792.)
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The Consequences of Poor Mental Health Care for Dementia Problems

Economic Benefits of

Quality Mental Healthcare

Overview: Psychiatric and Psychotherapy Economic Considerations

Leo J. Borrell, MD – Chief Medical Officer

A study by O'Brien and Caro[1] compared management levels and the annual costs of caring for nursing home residents with and without AD or other dementia. In this study of 49,724 nursing home residents, 26.4% had a documented diagnosis of dementia. Each of these patients required, on average, an additional 229 hours of care annually compared with residents without dementia, resulting in a mean additional cost of $3,865 per patient with dementia per year in 1997 dollars. In 2005 dollars, this would translated to approximately $4,700 per patient per year. [2]

Problem behaviors add costs to long-term care. Physical agitation, care refusal, and requests for attention were among the most frequently observed problem behaviors in a study of AD patients in long-term care settings.[3] Management strategies for these behaviors typically took one or more nursing staff an **estimated 5 to 20 minutes to put into practice, at a cost of $1.35 to $4.09 per episode (2000 dollars; $1.53 to $4.62 inflated to 2005 dollars**). Behavioral problems have been specifically measured in some studies with donepezil[4-6] and rivastigmine.[7] These studies show that treatment has a positive impact on measures of behavior. Because behavior problems are costly, cholinesterase inhibitors may reduce the cost of handling problem behaviors in long-term care. In fact, discontinuing cholinesterase inhibitor treatment is associated with a significant increase in daily labor costs. Nursing home residents who discontinued the medication incurred a mean daily labor cost of $55.16 compared with $49.60 at baseline. Patients who continued donepezil incurred a mean of $6.90 less per day than patients who discontinued.[8]

A 2004 article on the use and cost benefits of cholinesterase inhibitors in long-term care reviewed both cost-saving and cost-effectiveness data.[9] The authors concluded that given the cost of drug therapy, the difficulty in correlating cognition and behavioral scoring tools with disease severity, and the applicability of community costs prior to nursing home care, the results of the current data are equivocal at best. However, there is the real consideration of resident quality of life, maintained independence, and nursing home caregiver burden; which all need to be studied in some manner.

Diagnosis and Treatment of Mental Health Problems in Seniors

50% of patients with dementia and depression are undiagnosed. Thus, the proportion of older adults who received a depression diagnosis is at least doubled. Of those diagnosed, the proportion receiving antidepressants increased from 53.7% to 67.1%, whereas the proportion receiving psychotherapy declined from 26.1% to 14.8%. These shifts are most pronounced in groups with less-severe depression, in whom evidence of efficacy of treatment with antidepressants alone is less clear.

Depressive symptoms predict a range of negative outcomes, including total mortality, suicide, hospitalization, and medical complications in long-term care, and have been estimated to reduce active life expectancy at age 70 by 6.5 years for men and 4.2 years for women. Antidepressants have been shown to have clear efficacy for treatment of major depressive disorder (MDD), and psychotherapy has been demonstrated to be efficacious as well. More uncertainty exists concerning their efficacy for other depressive disorders.

There is consensus that combined treatment of psychotherapy and antidepressants resulted in fewer relapses than either treatment alone.

From 1991 to 2005 the total number of antidepressant prescriptions paid by Medicaid rose 380%.

Although studies suggest that psychotherapy and antidepressant treatment in combination may produce better outcomes for depression than either treatment alone, such treatment became increasingly rare by 2002 to 2005, declining by 39%.

The overall pattern was generally one of significantly greater antidepressant use across age. No significant increase was observed for older African Americans or Hispanics.

Of those who received other diagnoses, a sharp decline was observed – from 18.6% to 5.6%. Declines in psychotherapy in the community use were particularly notable in the subgroups with the highest rates of use in the earlier period. From 1992 to 1995 use of psychotherapy was moderately prevalent in men (34.2%), those aged 65 to 74 (29.5%), those with post-high school education (41.5%), those in metropolitan areas (31.4%), and those without ADL impairment (30.2%). From 2002 to 2005 the adjusted odds of treatment declined by 71% for men, 50% for those aged 65 to 74, 50% for whites, 62% for those with post-high school education, and 56% for those in metropolitan areas. It is estimated that less than 15% of residents in nursing homes receive adequate psychiatric and psychological care. This is probably less that 5% in rural areas.

There was a decline in the odds of receiving combined psychotherapy and antidepressant treatment, which was particularly marked for men (a 61% decline in the odds), whites (a 34% decline), and higher-income beneficiaries (a 43% decline). By 2002 to2005 approximately 50% of beneficiaries receiving care from a psychiatrist received combination therapy. Although a slight decline in combination therapy (from 50% to 45%) was observed. **For beneficiaries who did not receive care from a psychiatrist, use of combination therapy was rare and continued to decline to as low as 4%.**

DISCUSSION

The decline in use of psychotherapy in nursing homes is more severe since only 50% of nursing home patients are diagnosed with mental health problems and only 50% have service by mental health professionals. Thus is it likely that 15% receive psychiatric care or psychotherapy.

The proportion of older adults diagnosed with depression who received psychotherapy in the community declined by almost half (from 26.1% to 14.8%). Many providers whose practice patterns may be affected by efforts to promote depression care in general medical settings, largely through medication management, nonetheless serve these beneficiaries. By the end of the study period, fewer than half of those diagnosed with MDD and only 5.6% of those diagnosed with other depression received psychotherapy. Thus, greater reliance on medication-only regimens raises the possibility that combined treatment is being underused for some beneficiary+ groups. This has led to greater use of antipsychotics in long-term care settings because of behavioral problems, resulting in over-sedation, increased falls, concerns about chemical restraints, and a decrease in quality of life and care.

Declining rates of psychotherapy in those diagnosed with depression may also have a particularly adverse effect on those who do not wish to consider psychopharmacological approaches, an attitude that may be common in African Americans. It is troubling that only 51% of older African Americans diagnosed with depression received an antidepressant, and only 17% received psychotherapy, suggesting that psychotherapy does not fill the gap in treatment that results from lower antidepressant use in depressed older African Americans.

With respect to age, a greater increase in rates of antidepressant use in the oldest-old than in the youngest-old were identified. A gap in treatment rates in urban and rural areas was also identified, probably reflecting differences in supply of mental health services, because antidepressant use rates were similar in both areas, but psychotherapy use was much less common in rural areas.

A more balanced approach would seek to expand the availability of promising psychosocial interventions. Many people may benefit from a care plan that includes more than medication to achieve response or remission. A large study of late-life depression reported that a collaborative care intervention model (incorporating education, care management, antidepressant management support, brief psychotherapy) was associated with a substantial decrease in depression symptoms and remission (16.7% in usual care vs. 30.1% in the intervention group). Another study found that a home-based intervention for chronically medically ill older adults with depressive symptoms combining a problem-solving oriented psychosocial intervention with antidepressants as needed achieved better outcomes than usual care. This seems to be more of a problem in long-term care because of a lack of proper diagnosis, lack of psychiatric involvement, lack of confidence, and PCP's lack of understanding the value and benefit of psychotherapy and appropriate use of anti-dementia medications, antidepressants, and mood stabilizers. This also results in a lack of appropriate training of staff for diagnosis management of psychiatric problems.

Current research suggests that treatment quality varies because of early dropout from psychotherapy, medication non-adherence, and other factors.

In summary, an increase in treatment rates and substitution of treatment modalities marked the study period, with antidepressants substituting for psychotherapy and the diffusion of newer antidepressants. Research shows that the lack of psychiatrists' involvement impacts the ability of long-term care facilities to recruit mental health professionals, educate, and coordinate the nursing staff, families, the mental health team and PCPs, and provide efficacious psychotherapies for depression. This has led to declines in use of psychotherapy, alone or in combination with medication. It is clear that there is underuse of this treatment modality in the community and in long-term care facilities in the treatment of older adults with depression.

CONCLUSION

Quality Care for Dementia Makes Dollars and Sense

Annual Costs of Caring for Residents with and without AD

- 26.4% had documented dementia
- Average additional 229 hours of care per year
- Average additional $4700 per patient with dementia per year
    - **Problem behaviors add costs to LTC**
    - **Cholinesterase inhibitors may reduce this cost**
    - **Residents with this medication, $49.60 a day**
    - **Residents who discontinued it, $55.16 a day**

SUMMARY

What research shows about treatment of mental health problems in nursing homes:

1) 51% of participants with dementia and depression did improve their quality of life.
2) 58% of those with depression alone, receiving the comprehensive intervention had recovered from their depression six months later and had a better quality of life.
3) Only 25% of those receiving unsupplemented general practitioner care decreased depression, but they did not have significantly better quality of life.

Without psychotherapy, individuals with depression or dementia or both:

- 20% continued to exhibit behavioral symptoms.
- 40% exhibited physically and/or verbally aggressive behavior

Early evaluation and accurate comprehensive diagnosis is necessary. Medications alone are not enough. A comprehensive plan of 6-24 months with counseling is necessary to maximize results, prevent relapse and improve the quality of life.

Management of Aggressive Behavior	Cost Savings Per Year
Utilizing medications and psychotherapy	$3500/year
Utilizing Depakote rather than atypical antipsychotics	$2500/year
Maintaining a use of Donazepil	$2500/year
Total Cost Savings Per Patient Per Year	**$8500/ year**

There are approximately 41,000 Medicaid residents in nursing homes. 80% have dementia. 80% have mental health problems. 80% are not receiving adequate psychiatric care. If they did receive adequate care, the nursing homes of Texas would save $170 million to provide better medical care to other seniors.

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Patients who continued Donazepil incurred $6.90 less per day, cost savings of over $2500 per year!

Skilled Nursing Facilities

- The average cost of a fall in a SNF is $800.
- Fall-related hospitalizations average $1200.
- The annual direct cost to skilled nursing facilities = $7 Billion

Rochester Divalproex Study

- N = 56 agitated dementia patients in nursing homes.
- Randomized, double-blind, placebo controlled.
- Best dose (mean 826 mg/day) versus placebo for 6 weeks
    - Target Symptoms
        - Verbal Agitation = 93%
        - Physical Agitation = 93%
        - Aggression = 93%
        - Socially Inappropriate = 5%

Benzodiazepines: Nursing Home Residents Experiencing Falls

- Lorazepam 40%
- Divalproex 5%

Annual Cost of Psychotropics

Depakote ER 500 mg QD	$ 588
Risperdal 0.5mg	$ 960
Zyprexa10 mg	$3120

* It is important also to use: Namenda, Aricept and Antidepressants; Lexapro, Effexor and Cymbalta as well as stimulants; Provigil
Appropriate pain management, not just prn Darvocet

Quality Care from An Administrator Perspective

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Reality of Disclosure and Individuals with Dementia

- **50% OF PRACTIONERS DO NOT DISCLOSE DEMENTIA DIAGNOSIS**
- Only 47% knew correct diagnosis
- 66% said no one ever spoke with them about their illness
- 92% wanted to know to plan for the future and enjoy present while they could
- 65% were told after family was told
- 51% “reacted poorly” per family

Part II (See: The Reality of the Need – Part II for the following information:)

References and Resources

Apart from Nihilism and Stigma What Influences General Practitioners' Accuracy in Identifying Incident Dementia (by Pentzek, et al. *Am J. Geriatr*)*Psychiatry* 2009

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Comorbidity: Psychiatric Comorbidity in Persons with Dementia (Shub & Kunik, *Psychiatric Times* 2009)

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Advances in Psychotherapy for Mental Illness in Late Life (Arean PA. Am J Geriatr Psychiatry 2003)

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Indicators of the Quality of Nursing Home Residential Care

Issues in Dementia Caregiving: Effects on Mental and Physical Health, Intervention Strategies, and Research Needs (Sorensen S, & Conwell Y)

Psychiatric and Psychotherapy Economic Considerations (Bright-Long, Lori)

Reducing Psychotropic Drug Use is Easy-Evidence Based Medicine

The Continuing Paradoxes of Nursing Home Policy

Working with Families of Hospitalized Older Adults with Dementia (Hall, G., Maslow, K. The Hartford Institute for Geriatric Nursing 2007, No. D10)