

Older Adults and Clients with Dementia Who Have Psychiatric/Behavioral Symptoms: Issues Related to Psychiatric Hospitalization and Institutional Placement (Nursing Homes and Assisted Living)

Introduction: “The Crisis”

The Older Adult population is expanding rapidly, and perhaps in anticipation of the increased costs of care this will bring, there has been a gradual process of "defining older persons out" of the existing mental health system of services. This has been done by excluding Dementia as a valid diagnosis for admission even if the client meets all criteria for involuntary commitment, assuming that Nursing Homes can provide for acute psychiatric needs when Nursing Homes are not appropriately staffed and have greater restrictions on the use of restraining safety measures than do psychiatric hospitals, and by establishing Priority Population/SMI criteria that favor those under age 65.

1. State Hospital policy on admissions for clients with Dementia:

In order for an adult with a diagnosis of Dementia to be hospitalized in the State mental health system, the request must go through the Receiving State facility (Eastern State Hospital or NVMHI for under age 65 clients). ***Without directly examining the client***, Eastern State must concur that the “behavioral” problems are acute and will remit with inpatient care. The State Hospital, therefore, has the right to refuse hospitalization to adults with Dementia even if those clients meet legal commitment criteria. (See Appendix A)

Dementia clients can be denied a state hospital bed by the receiving facility even if a bed is available in the hospital. Without the designation of a bed, CSB staff cannot proceed to a commitment hearing, even if the client meets commitment criteria based upon the pre-commitment screening. (See Appendix A)

Issues:

Clients of any age who have a diagnosis of Dementia can be denied psychiatric treatment in a State Psychiatric Hospital even if their behavioral symptoms are identical to clients without a diagnosis of Dementia, and even if their behavioral symptoms are sufficient to meet commitment criteria.

In the current system, the denial of treatment of a Dementia client in a State Psychiatric Hospital is done on the basis of a written or verbal report, not upon a face-to-face assessment of the individual. In effect, the face-to-face assessments built in to the pre-commitment screening and the commitment hearing to prove the individual's least restrictive level of care is involuntary commitment can be over-ridden by someone in a State psychiatric Hospital reading or taking a verbal report.

2. State Hospital Availability:

Western State Hospital Geriatric Center has closed. Northern Virginia Clients who are 65 and over now are in the Eastern State catchment area. The Local State mental hospital, NVMHI does not admit clients 65 and over for any mental health reason. (See Appendix B).

Issues: Clients over age 65 can generally be considered the frailest of mental health clients, yet anyone in this age group who requires state psychiatric hospitalization must travel even greater distances than previously and are denied local state hospitalization. Such clients also have the frailest of social supports. Friends and family of older adult clients may find travelling to Eastern State an insurmountable hardship compared to a local location. Persons providing social supports, therefore, are limited in their participation in treatment and discharge planning.

3. Nursing Homes as Alternative to Hospitalization

Older adults and Dementia clients with behavior problems are often referred for Nursing Home placement. Those clients who have a psychiatric diagnoses or exhibit behavioral symptoms indicative of a psychiatric diagnosis must pass a Level II pre-screening required by Medicaid before admission to a Nursing Home. The purpose of the Level II pre-screening is to ensure that older adults with mental health problems receive active psychiatric treatment, including inpatient hospitalization, before being accepted into a nursing home. Those clients with a Dementia diagnosis, regardless of whether or not they exhibit behavioral symptoms indicative of a psychiatric diagnosis, are exempted from the Level II pre-screening. (See Appendix C)

Issues

Older adults who need supervised care may be denied nursing home placement because of mental health/behavioral problems, but may also be denied psychiatric treatment in a State Mental Hospital because of their age/diagnosis of Dementia. Where are such individuals to go?

If the older adult has a diagnosis of Dementia, he may be admitted to a nursing home even though he is in need of inpatient psychiatric treatment. He may, therefore, receive the supervision required but be denied the level of psychiatric treatment he needs.

Although psychiatrists may see clients in nursing homes, they cannot do so as intensively as on a psychiatric unit. Furthermore, the 24 hour support staff on a psychiatric unit are expert in the care and treatment of persons with psychiatric illness. One cannot expect to find such expertise in a nursing home, even among

highly skilled staff. The expert monitoring and intervention on the psychiatric unit, therefore, cannot be performed in a nursing home.

Nursing homes have restrictions by regulation to use some interventions essential in the treatment of extremely behaviorally disordered clients. These include stringent regulations against the use of chemical or physical restraints which are permitted to be used in psychiatric hospitals; therefore, hospitals have the tools necessary to ensure the safety of clients and staff while waiting for other treatments to become effective, while nursing homes do not. (See Appendix D)

4. Hospitalizing in Private Psychiatric Hospitals/units – Another Double-bind

Private psychiatric facilities may appear to be the solution to the above problems involving nursing homes and State Psychiatric Hospitals; however, private psychiatric hospitals, who depend upon third party payers for their survival, may deny admission of older adults or Dementia clients unless there is a guarantee that there is a place for them to go after discharge or after their insurance days expire.

Additionally, clients with severe Dementia lack the capacity to sign themselves in to a psychiatric hospital voluntarily, but, by law, a guardian cannot sign the client in to a psychiatric hospital (A guardian can sign a client in to a hospital for medical treatment, however). (See Appendix E)

Involuntary commitment in a State Mental Hospital becomes the only alternative.

Issue:

The criteria for involuntary commitment are much more strict than the criteria for voluntary admission to a psychiatric hospital. If a Dementia client does not have the capacity to sign himself in for a voluntary hospitalization, voluntary hospitalization for psychiatric/behavioral problems is a treatment denied him. A non-demented client with the same psychiatric symptoms, however, will have access to voluntary hospitalization.

At best, the Dementia client will be made to endure longer periods of suffering than his non-demented counterpart, and will have fewer cognitive resources to cope with such suffering.

At worst, treatment may be denied to the Dementia client until his condition deteriorates to levels that would meet involuntary commitment criteria, levels which may also compromise his health, his safety, his life. (and as discussed above, reaching commitment criteria is no guarantee that a State Mental Hospital will agree to treat the client)

Emergency Services through the CSB are tasked with pre-screening for detention/commitment. The usual procedure is to seek detention in a private psychiatric facility if the pre-commitment screening shows that commitment criteria are met. Under some circumstances, a non-demented client has the right to agree to voluntary psychiatric hospitalization and avoid commitment. A Dementia client who lacks capacity is denied this right.

Additionally, there is always the possibility that a client initially detained or committed to a private facility may eventually need to be transferred to a State facility. In such instances, the same impediments to psychiatric hospitalization in State Mental Hospitals exist that have been discussed above.

Clients experiencing severe Dementia who lack capacity are denied voluntary psychiatric hospitalization and are restricted from State hospitalization by regulations that do not apply to clients who do not experience dementia.

5. Maintaining Nursing Homes as a Resource

Nursing Homes, Assisted Living Facilities and Group Homes are, thus, often caring for clients whose behaviors render them inappropriate for such settings. Statistics show that nursing home populations have a high rate of psychiatric illness; therefore, their clients may be expected to need psychiatric hospitalization at rates higher than other populations. But, for the reasons discussed above, the nursing home population (mostly older adults and/or demented) have almost insurmountable restrictions on being hospitalized psychiatrically when the need arises.

Issue:

Nursing home facilities have become more and more reluctant to accept clients who have a psychiatric diagnosis, or who exhibit difficult behaviors. Nursing homes do not have the resources to care for such clients when their psychiatric conditions deteriorate, and nursing homes cannot rely on the Mental Health system to assist them when such clients require psychiatric hospitalization, including when such clients meet the criteria for involuntary commitment.

6. Priority Population/SMI criteria are not written with Older Adults in mind.

The State mandates a priority for the treatment of the most psychiatrically ill client, but the criteria to include clients in priority categories favors those persons under age 65. (Appendix F)

For example, the criteria for Priority Populations/SMI designation include ability to function well enough to maintain employment, but most older adults are not in the work force, as their age qualifies them for Social Security.

The Priority Population criteria specifically exclude diagnoses of Dementia. (Appendix F)

Issue:

The Priority Populations/SMI criteria are not written with the issues of the older adult in mind; therefore, fewer older adults qualify for this designation and fewer State dollars are available for services for this population. As has been described over and over in the above, however, older adults are one of the most vulnerable of populations and a population that currently has mental health resources denied them. At the same time, the population of older adults is the fastest growing of all age groups.

Conclusion:

These problems have been observed by professionals in the Older Adult Programs of Community Services Boards, and have been corroborated by Aging and Dementia Advocacy Groups, Emergency Mental Health Services, Health Organizations, Social Services Agencies and Adult Protective Services Agencies.

In Summary, the Older Adult population is expanding rapidly, and perhaps in anticipation of the increased costs of care this will bring, there has been a gradual process of "defining older persons out" of the existing mental health system of services. This has been done by applying different and more stringent admission criteria at State Hospitals than are used for those under age 65, excluding Dementia as a valid diagnosis for admission even if the client meets all criteria for involuntary commitment, assuming that Nursing Homes can provide for acute psychiatric needs when Nursing Homes are neither appropriately staffed nor can use restraining safety measures used by hospitals, and by establishing Priority Population/SMI criteria that favor those under age 65.

If left unaddressed, the problems outlined in this paper will compound as the aging population increases in number.

Recommendations for beginning the process of addressing issues related to the mentally ill geriatric population:

1. We request a study to be done by an independent group on the following four older adults with mental illness issues:
 - Psychiatric hospitalization, both public and private
 - Institutional placement, including nursing homes and assisted living facilities
 - Age appropriate availability of the full range of services offered by Community Mental Health Centers, including psychosocial day programming, housing, emergency services and outpatient treatment services, and
 - Private community resources.

We would like the study to look at the cascading impact of the decisions that have been made to reduce the number of in-patient geriatric beds in the State system, we would like the study to look at the problems of hospitalizing geriatric clients who are in need of psychiatric hospitalization, including those with Dementia, we would like the study to look at the long-term care needs of older adults who are mentally ill and we would like the study to look at the availability and age-appropriateness of the full range of services in community mental health centers.

2. We recommend that the criteria for Priority Populations be re-written to be more inclusive of older adults, and adults who have behavioral and psychiatric symptoms related to Dementing illnesses.