USF UNIVERSITY OF SOUTH FLORIDA
Florida Policy Exchange Center on Aging
College of Behavioral and Community Sciences

Policy Brief # 2 **June 2010**

Reasons for Psychiatric Medication Prescription for New Nursing Home Residents.

BACKGROUND

Appropriate mental health services provided to nursing home (NH) residents has been a topic of some controversy over the past few years.

THE STUDY

This report focuses on the prescription of psychoactive medication to newly-admitted NH residents during their first three months of admission.

STUDY METHOD

The methodology involved extraction of information from 73 charts drawn from a convenience sample of seven NHs to determine the presence and rationale for psychoactive medication use. Six focus groups with NH staff were conducted to explore rationale for psychoactive medication usage documented in the record abstractions.

FINDINGS

A number of findings suggest that NH residents with mental health problems receive attention and treatment:

- The old lore that there is limited treatment for addressing the mental health problems of NH residents can safely be put to rest, at least in Florida! On a very broad 'big picture' level, many residents have mental health problems and most receive treatment in the hospital prior to placement and during their NH residence. Eighty-nine percent of the residents who receive psychoactive medications have a psychiatric diagnosis and all residents who are on psychoactive medications have a written physician's order. Mental status is monitored by the staff, with psychoactive medications both being added and dropped. Nearly three-fourths of NH residents on psychoactive medications have at least one note in the chart justifying psychoactive medication prescription. Over 92% of the residents have at least one note in the chart regarding a behavior that merited attention; 83% of those residents who had a psychoactive medication added or dropped had a specific target symptom identified, 63% of those residents who had a psychoactive medication added or dropped had some behavioral monitoring prior to psychoactive medication prescription. Impressively, half of the residents received additional mental health consultation, and 59% of the NH residents had at least one note reflecting the monitoring of side-effects. Focus group data suggest that the NH staff seems reasonably knowledgeable of how to address the mental health problems of residents (i.e., to individualize treatment, be flexible, don't use psychopharmacology as a first resort). However, they are concerned about how to remedy the medication regimens with which new residents are discharged from the hospital to the NH, and they recognize the need for more communication/teamwork and training to address the mental health needs of the residents.

Several of the findings however do raise concerns:

- No PASRR 2's were completed. Almost all the PASRR 1's in the charts indicated that the incoming NH residents did not have a mental disorder (despite the fact that 70% of the residents were admitted with a psychoactive medication, and a rule to say that behavior problems should trigger a PASRR 2). In informal discussions with NH administrators regarding this matter, it appears that there is a genuine difference of interpretation regarding when a PASRR 2 is needed. Their belief appears to be that PASRR 2's are triggered by longstanding diagnoses of Serious Mental Illness, rather than the more common psychiatric problems reflected in mental status changes related to dementia. It also should be noted that NH administrators appear to be concerned about the mental health problems of their residents, often resorting to referrals regarding mental health consultation rather than the PASRR system to evaluate mental status changes of residents. The PASRR process appears to be viewed as a bureaucratic hurdle rather than as a way of assuring

adequate mental health assessment of all NH residents who need it. Perhaps these different interpretations of PASRR justify continuing education on this issue, some further specification in guidelines, or even a complete evaluation of the outcomes of the PASRR 2 process and whether the outcomes are consistent with the original goals.

- Over 85% of the NH residents were on a psychoactive medication within three months of admission, and 13.7% were on four or more psychoactive medications. This is consistent with our prior research suggesting high use of psychoactive medications, and highlight continued concerns with adverse side-effects and untoward medical events. It should be noted that 68% of the NH residents were admitted with at least one psychoactive medication. However, perhaps more striking is the fact that 84% of the NH residents were admitted from the hospital, and 84% of these residents were admitted on at least one psychoactive medication. These results strongly suggest that NH residents are on a psychoactive trajectory prior to and upon admission to the NH from the hospital, and that a point of entry for interventions regarding psychoactive medication usage could be at discharge from the hospital and upon NH entry to determine the absolute necessity for each resident's psychoactive regimen. Indeed, one member of the focus group indicated the NH staff often have to "clean up" the situation they inherit from the hospitals who don't have strict rules and regulations regarding psychoactive medications. As noted above, another point of intervention might be a broader interpretation of the need for PASRR 2's so that on the front end an extended mental health assessment can be conducted and yoked to a mental health treatment plan that is regularly monitored.
- Although over half of the residents had notes in their charts regarding non-psychopharmacological strategies to address problem behaviors, this number is dwarfed by the 85% who receive psychopharmacological treatment. The intent of OBRA was to promote non-psychopharmacological strategies as a first-line treatment to address psychiatric problems of NH residents and this goal has yet to be achieved. Even though there may be other non-psychopharmacological strategies that are informally utilized that are not noted in the charts, the non-psychopharmacological strategies mentioned in the charts are basic, general interventions. It is worthy of mention that there do not appear to be any notes regarding interventions delivered by trained licensed mental health professionals, although our data collection process was unable to provide definitive evidence for this. On the basis of these chart reviews, it appears that psychoactive medication usage remains the primary strategy to address the mental health problems of NH residents.

DISCUSSION AND POLICY RECOMMENDATIONS

Overall, our study suggests there is a good deal of mental health care that occurs in NHs. The question remains, how optimal and effective is this care? In this study, it appears that a high percentage of NH residents are being treated for specific mental health problems for which they are diagnosed and then monitored regarding the effects of the treatment. Approximately one-half receive outside mental health consultation. Most residents receive psychoactive medications, and over-half receive non-psychopharmacological care broadly defined. The big question is whether there is an over-reliance on medication-based mental health interventions, a concern particularly for those ~15% of the residents found in the current and prior study of Florida NHs who take are taking four or more psychoactive medications.

It does appear that psychopharmacological care continues to be a major strategy used by NHs to address the mental health problems of residents. NH staff and administrators appear sensitive to the mental health needs of their residents, but they are faced with residents who have multiple medical and psychiatric problems. The need for continued mental health training of staff, the lack of available geriatric mental health professionals, and perceptions that PASRR rules may hinder rather than assist in targeting mental health problems may encourage NHs to resort to psychopharmacological care as a primary way of attempting to resolve a NH resident's distress.

A major question raised by the results is whether there are cost-efficient mechanisms that can be implemented to assure that the spirit and intent of OBRA is realized in all Florida NHs, and that a variety of valid evidence-based mental health interventions are available that can be tailored to the unique psychiatric circumstances of each resident. It is possible that with more clarity in the interpretation of PASRR rules triggering evaluations, or other mandatory non-PASRR type mental health evaluations, more optimal mental health treatment will occur. The requirement for a comprehensive evaluation of the need for psychiatric medications upon entry into the NH (at least for those from hospital settings) by qualified geropsychiatrists or geriatricians should also be considered.

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