Section I Comprehensive Mental Health Services

Chapter 1

The Need for High-Quality Comprehensive Mental Health Services in Long-Term Care

Long-term care is simply a means to ensure that older people with a significant loss of capacity can still experience *Healthy Ageing*.
World Health Organization, World Ageing and Health Report *(2015; emphasis added).*

Conservative estimates are that one in four older adults (age 65 or older) is currently receiving long-term care (LTC) (World Health Organization 2015). This means that millions of older adults around the world are currently receiving LTC. More than 15 percent of adults receiving LTC are younger than age 65. Adults receiving LTC are typically severely disabled due to advanced physical health problems and/or major neurocognitive disorders (MNCD), primarily dementias (Rosenblatt and Samus 2011). They require 24-hour functional support and assistance with basic activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and/or have advanced MNCD with significant behavioral and psychological symptoms. With the aging of the population, the number of adults in LTC is expected to triple in the next two decades.

LTC is typically provided in a facility staffed with health care professionals (Sanford et al. 2015). For the majority of residents, this becomes their home for the rest of their life. Often, a section of the facility provides skilled rehabilitation to promote recovery of function after acute hospitalization so that individuals can be discharged back home. Such rehabilitation typically involves intensive physical, occupational, and/or speech therapy and/or complex medical initiatives (e.g. intravenous antibiotics, total parenteral nutrition, management of pressure ulcers). Although admissions to LTC are usually from home or another LTC facility, a substantial proportion of admissions are from the rehabilitation section, where the resident has made insufficient progress in recovering function to live safely on his or her own and has insufficient resources to be cared for safely at home.

The Spectrum of Long-Term Care

LTC primarily includes nursing homes (NHs) and assisted living (AL) (in the United States), long-term care homes (in Canada), residential aged care homes (in Australia), and similar facilities in other countries (Sanford et al. 2015). The spectrum of residents in LTC ranges from very disabled individuals living in NHs, AL homes, special care units, and hospice, to less-disabled individuals living in community-based residential facilities, small foster care homes, board-and-care or personal care homes, or congregate housing, as well as people in retirement communities who receive assistance with ADLs or whose medications are monitored.

LTC settings are making efforts to adopt a more person-centered approach that emphasizes independence, dignity, privacy, decision-making, autonomy, and aging in place (Morley 2012). Besides providing complex physical-health-related services, the majority of LTC facilities also provide oversight of personal and supportive services, social services, recreational activities, meals, housekeeping and laundry, and transportation. Although the public perception is that no one likes living in a LTC facility, many residents prefer the reassurance of medical care, socialization, and a safe environment, and they find the experience to be positive. Many family members of the residents also find some relief in knowing that their loved one is safe and receiving the complex care they are unable to provide at home.

The Epidemiology of Psychiatric Disorders among Residents in Long-Term Care

At least one in three residents in LTC at any given time has a treatable serious psychiatric disorder, and one in five has two or more treatable psychiatric disorders (Commission on Long-Term Care 2013; Steiz, Purandare, and Conn 2010). If we include the

management of MNCD (dementias), then four out of five residents in LTC at any given time would benefit from psychiatric treatment (Desai and Grossberg 2017). This, combined with high point prevalence of use of multiple psychotropic medications (15–30 percent) (psychotropic medications are medications used to treat psychiatric disorders) and psychiatric mismanagement, results in substantial psychological and functional morbidity (Jacquin-Piques et al. 2015; Kotlyar et al. 2011; Vasudev et al. 2015; Wei et al. 2014). (See Tables 1.1 and 1.2.) In addition, psychiatric disorders have a substantial negative effect on

Table 1.1 Prevalence, Key Concerns, and Evidence-Based Approaches by Mental Health Team for Common Psychiatric Disorders in Long-Term Care Populations

Psychiatric Disorder (Point Prevalence [%])	Key Concerns and Common Examples of Psychiatric Mistreatment or Undertreatment	Evidence-Based Approaches and Therapeutic Pearls
Major neurocognitive disorders (MNCD) / Dementias (40–90)	– Undertreatment of reversible causes of cognitive impairment – Inappropriate use / nonuse of cholinesterase inhibitors and/or memantine	– Work-up to identify potentially reversible cause(s) of cognitive impairment – Appropriate use of cholinesterase inhibitors and/or memantine based on APA Practice Guidelines
Agitation and/or aggression as part of behavioral symptoms of MNCD (BPSD) (20–50)	– Overtreatment with psychotropic medication – Lack of knowledge, skill, and practice of nonpsychotropic approaches	– Discontinue antipsychotics and, if necessary, replace them with safer alternatives such as citalopram or dextromethorphan-quinidine (both off-label) – Staff training in person-centered care, communication skills, dementia care mapping, and SPPEICE (strength-based, personalized, psychosocial sensory spiritual environmental initiatives and creative engagement)
Depressive Disorders (include depression due to a MNCD) (10–30)	– Use of antidepressant to treat adjustment disorder – Suboptimal use of antidepressant for moderate to severe major depression and failure to recommend electroconvulsive therapy for severe/psychotic depression	– Discontinue antidepressants and institute SPPEICE (e.g. individualized pleasant activity schedule, individual psychotherapy) – Optimize appropriate antidepressant treatment based on APA Practice Guidelines for treatment of major depressive disorders
Prevalence of delirium (2–5; may be up to 50% in newly admitted residents receiving rehabilitation after hospitalization)	– Hypoactive delirium often mistaken for depression or diagnosis missed. – Underdiagnosis of medication-induced delirium	– Comprehensive psychiatric evaluation (CPE) to accurately differentiate depression from delirium – High index of suspicion for medication-induced delirium (especially medications on Beers list)

Table 1.1 (cont.)

Psychiatric Disorder (Point Prevalence [%])	Key Concerns and Common Examples of Psychiatric Mistreatment or Undertreatment	Evidence-Based Approaches and Therapeutic Pearls
Depression due to undertreated chronic pain (5–15)	– Underuse of nondrug approaches to manage chronic pain – Underuse of antidepressant to treat chronic pain	– Educate staff regarding nondrug approaches to manage chronic pain (e.g. relaxation strategies, cognitive strategies, hot and cold compresses, physical therapy, music, distraction) – Improve use of appropriate antidepressants to treat chronic pain
Psychotic symptoms due to MNCD and/or due to a general medical condition or to medication (5–15)	– Inadequate work-up to clarify etiology of psychotic symptoms – Overuse of antipsychotics for management – Failure to recognize psychosis triggering severe agitation	– CPE to clarify etiology of psychotic symptoms and institute appropriate treatment – Implement SPPEICE and limit use of antipsychotics for severe symptoms – Use antipsychotics judiciously and promptly when necessary
Schizophrenia, bipolar disorder, and schizoaffective disorders (0–5)	– Suboptimal psychotropic medication therapy leading to poor symptom control and high frequency of adverse effects – Inadequate staff knowledge about the illness leading to countertherapeutic approach	– Optimize appropriate psychotropic medication therapy (PMT) for improved control of symptoms and lowered adverse effects – Educate and train staff
Anxiety disorders (5–10)	– Overuse of benzodiazepines for management – Inadequate use of relaxation, mindfulness-based, and distraction strategies	– Minimize use of benzodiazepines and replace them with safer approaches when appropriate (e.g. antidepressants, buspirone) – Case-based staff education and training regarding relaxation and distraction strategies they can help resident use
Post-traumatic stress disorder and other trauma-related disorders (0–5)	– Underdiagnosis of PTSD and related disorders – Suboptimal PMT	– Routine screening for PTSD and other trauma-related disorders among residents who have persistent anxiety, depressive symptoms, and/or resistance to care – Optimize appropriate PMT
Substance use disorder (addiction) and misuse of medications (2–10)	– Overuse of benzodiazepines and opioids in this population – Many staff see these problems as character flaws	– Taper and discontinue benzodiazepines and opioids and replace them with safer alternatives and SPPEICE – Case-based staff education
Mild to moderate agitation and aggressive behaviors, including resident-to-resident	– Under-recognition by staff that these behaviors usually are a reaction to one or more unmet	– Educate and train staff (e.g. train with *Bathing without a Battle* DVD)

Table 1.1 (cont.)

Psychiatric Disorder (Point Prevalence [%])	Key Concerns and Common Examples of Psychiatric Mistreatment or Undertreatment	Evidence-Based Approaches and Therapeutic Pearls
aggression and sexually inappropriate behavior in the context of MNCD (10–30)	needs (e.g. experiences and perspectives of residents being heard and understood, boredom, loneliness, pain, constipation) – Inappropriate use of PMT	and institute SPPEICE to better meet resident's needs – Taper and discontinue PMT
Severe and persistent agitation and aggressive behaviors in the context of MNCD (5–10)	– Undertreatment of multiple reversible factors contributing to these behaviors – Inappropriate and suboptimal PMT	– Identify and treat reversible contributing causes of these behaviors (e.g. pain, countertherapeutic staff approach) – Optimize appropriate PMT
Sleep disorders (5–15)	– Inappropriate use of hypnotics – Underuse of nondrug approaches	– Discontinue inappropriate hypnotics and optimize use of appropriate hypnotics – Institute sleep hygiene and other nondrug approaches
Personality disorders and personality change due to a neurological condition (1–10)	– Inadequate staff knowledge leading to countertherapeutic interactions with the resident – Staff stress and burnout while caring for these residents	– Case-based staff education and training and institute SPPEICE – Support and guide staff, educate and train staff in mindfulness-based strategies to prevent burnout
Psychiatric symptoms due to use of psychotropic medication (5–15)	– Apathy, anxiety, insomnia due to antidepressants and/or antipsychotics – Cognitive impairment due to anticholinergic effects of many commonly used psychotropic medications (e.g. amitriptyline, paroxetine)	– Taper and discontinue offending medications – Minimize use of psychotropic medications that have anticholinergic activity
Psychiatric symptoms due to inappropriate use of nonpsychotropic medication (5–15)	– Steroid- and opioid-induced mood, cognitive and psychotic symptoms – Psychotic symptoms and impulse control problems due to dopaminergic therapy used to treat Parkinson's disease and Parkinsonism	– Educate staff and primary care clinician and taper and discontinue steroids as soon as is feasible – Educate staff and primary care clinician and reduce dopaminergic therapy whenever feasible
Difficulty recognizing need for palliative and end-of-life care, especially for residents who have advanced MNCD	– Futile and burdensome care for residents in last phase of life, causing further decline in quality of life – Inappropriate/suboptimal PMT for treatment of depression, agitation, and pain	– Institute palliative and hospice care that is in keeping with resident's values and wishes – Optimal appropriate PMT to treat depression, agitation, and pain

APA: American Psychiatric Association

Table 1.2 Prevalence of Use of Common Psychoactive Medications in Long-Term Care Populations and Risks Associated with Their Use

Psychoactive Medications (commonly used) (Point Prevalence)	Key Serious Adverse Risks for Physical Health	Key Serious Adverse Risks for Mental Health
Antipsychotics (e.g. risperidone, haloperidol, olanzapine, quetiapine, aripiprazole, ziprasidone, paliperidone, iloperidone, lurasidone, brexpiprazole, asenapine, cariprazine) (5–20)	Decline in ADLs, falls, increased mortality and stroke risk among residents who have MNCD, drug-induced Parkinsonism	Cognitive slowing, apathy, restlessness, dysphoria
Antidepressants (e.g. citalopram, escitalopram, sertraline, mirtazapine, duloxetine, venlafaxine, paroxetine, trazodone, desvenlafaxine, vilazodone, vortioxetine, levomilnacipran) (10–30)	Falls, risk of bleeding if used concomitantly with blood thinners (e.g. NSAIDs, aspirin, clopidrogel, warfarin), hyponatremia	Apathy, insomnia, agitation
Benzodiazepines (e.g. lorazepam, alprazolam, diazepam, clonazepam) (5–20)	Falls, decline in ADLs	Cognitive impairment, delirium, daytime sleepiness, dependence
Opioids (e.g. hydrocodone, oxycodone) and tramadol (10–40)	Falls, decline in ADLs	Cognitive impairment, daytime sleepiness, delirium, dependence
Anticonvulsants (e.g. valproate, gabapentin) (5–15)	Falls, decline in ADLs	Daytime sleepiness, delirium
Hypnotics (e.g. zolpidem, zaleplon, eszopiclone) (5–20)	Falls	Daytime sleepiness, dependence

residents' quality of life, disability, mortality, care needs, and cost of care.

MNCD and delirium are two of the most common neurocognitive disorders seen among LTC residents. Behavioral and psychological symptoms of MNCD are the most common reason for psychiatric consultation. Between 70 and 90 percent of all people who have MNCD eventually develop one or more clinically significant behavioral and psychological symptoms. The lifetime prevalence of delirium (or acute confusional state) among LTC residents is more than 50 percent. LTC residents who are transferred to a LTC facility from a hospital have a high point prevalence of delirium (20–50 percent), especially after surgery to repair a hip fracture (American Geriatrics Society 2012).

Depression (both mild and moderate to severe) is the second category of psychiatric disorder prevalent in LTC populations. Moderate to severe depression among LTC residents occurs in 6–10 percent of the population with MNCD and 20–25 percent of those without MNCD, and 4.3 percent of residents develop new-onset depression within one year of admission to a LTC facility (Hui and Sultzer 2013). Mild depression is even more prevalent, and more than 20 percent of residents may have mild depression escalate to moderate to severe depression within one year. More than one-third of newly admitted residents may develop depressive symptoms by day 14, and the majority of these (66 percent) will continue to experience depressive symptoms on day 60. Less than half of the residents who do not improve have changes in their treatment. More than half of the residents who have moderate to severe depression continue to have moderate to severe depression, and almost one-third of those who have mild depression still have mild depression one year later. Thus, depression is undertreated in LTC populations. Although we have made strides in recognizing depression in LTC populations, it is under-recognized in many subgroups, especially among the oldest residents and residents who have neurocognitive impairment.

Psychotic disorders affect 5–15 percent of LTC residents, compared with 2–5 percent of community-dwelling older adults. More than 40 percent of residents who have MNCD due to probable Alzheimer's disease (AD) have some form of psychotic symptoms (e.g. delusion, hallucination) at some point during the course of that illness. The lifetime prevalence of psychotic symptoms in MNCD with Lewy bodies and with Parkinson's disease is even higher, reaching 90 percent. The prevalence of severe and persistent

mental illness (e.g. schizophrenia, schizoaffective disorder, bipolar disorder, recurrent major depression, post-traumatic stress disorder) ranges from 0.2 to 2.5 percent in LTC. Older persons who have schizophrenia or schizoaffective disorder make up the majority of these residents, although among veterans of war, post-traumatic stress disorder (PTSD) also makes up a substantial proportion.

Insomnia as a symptom and sleep disorders are prevalent in LTC populations and are associated with inappropriate use of hypnotics and other inappropriate and potentially dangerous pharmacological agents (e.g. sedating atypical antipsychotics, such as quetiapine) and inadequate use of sleep hygiene and other nondrug approaches (Gindin et al. 2014).

Resident-to-resident aggression is ubiquitous in LTC. Self-injurious behaviors (e.g. pinching or scratching oneself, banging one's fist against an object) are often seen among residents who are immobile. Sexually inappropriate behaviors are also common in LTC populations, especially among male residents who have frontal lobe damage or cerebrovascular disease.

The prevalence of psychotropic medication use is high in LTC populations (Jacquin-Piques et al. 2015; Vasudev et al. 2015; Wei et al. 2014). (See Table 1.2.) The point prevalence of the use of two antidepressants is high (5–15 percent) and of two or more psychotropic medications is even higher (15–30 percent). The use of antipsychotics especially is worrying because of the significant risk of stroke and mortality associated with its use by individuals who have MNCD. On average, more than 10 percent of LTC residents are taking an antipsychotic at any given time; additionally, more than half are receiving an antipsychotic at a dose exceeding the maximum level, are receiving duplicative therapy, and/or have inappropriate indications. More than 25 percent of residents who have dementia and spend more than 100 days in a LTC facility are prescribed an antipsychotic. Antipsychotics and hypnotics are often prescribed in the hospital, and these medications are continued after admission to a LTC facility, especially when staffing levels are low. In addition, there are considerable gaps between the psychotropic medications that clinical evidence recommends and the psychotropic medications that clinical practice delivers. The use of antidepressants and antipsychotics by LTC residents who have MNCD has risen dramatically, and these medications are primarily administered to manage behavioral and psychological symptoms associated with MNCD.

The proportion of LTC residents who have serious behavioral problems (especially aggressive behavior toward staff and/or other residents) ranges from 30 to 50 percent and typically is part of behavioral symptoms accompanying MNCD.

Psychosocial and Medical Complexity of Long-Term Care Residents

In demographics, residents of LTC facilities are typically older than 75, and female residents are older than male residents (mean age 83 versus 76) (Rosenblatt and Samus 2011). The majority are women (70 percent), and more than 40 percent of all residents are 85 years of age or older (Erol, Brooker, and Peel 2015; Commission on Long-Term Care 2013). Most residents are not living with a marital partner, and more than 50 percent are widowed. More than 50 percent of admissions to LTC are unplanned and/or the resident has not been involved in the decision. Most LTC facilities are located in a metropolitan area, where mental health professionals are more available than in rural areas. Admission to LTC is strongly associated with age and the presence of advanced MNCD, even after adjusting for disability (Brodaty et al. 2014). The majority of LTC residents have multiple treatable comorbid physical health problems that are often undertreated (Table 1.3). At least one in five residents needs assistance with three to four ADLs. Additionally, the functional status of most residents usually declines with time.

Physical health conditions are typically in advanced stages and more disabling among LTC populations than among community-dwelling age- and gender-matched adults (Table 1.4) (Rosenblatt and Samus 2011). Almost 80 percent of the patients hospitalized for a stroke and 65 percent of the patients hospitalized for a hip fracture are discharged to skilled nursing facilities for rehabilitation services. The psychosocial well-being of LTC residents is also significantly influenced by comorbid physical conditions. Sensory deficit, urinary tract infection, dehydration, constipation, musculoskeletal pain, electrolyte imbalance, falls, and the mood- and mind-altering effects of commonly prescribed drugs are some of the most common treatable physical conditions encountered among LTC populations. Significant hearing impairment and vision impairment

Table 1.3 Common Untreated or Undercorrected Physical Health Problems among Long-Term Care Residents Who Have Psychiatric Disorders

Physical Health Problem	Point Prevalence (%)	Key Mental Health Concern Associated with the Physical Health Problem
Hearing deficit	20–50	Depression or paranoia
Vision deficit	10–30	Depression, visual hallucination or illusion
Pain (acute, acute over chronic, chronic)	10–25	Depression, agitation, aggression
Constipation	20–60	Depression, agitation, aggression, delirium
Dehydration	5–15	Depression, fatigue, delirium
Urinary incontinence	5–20	Agitation, aggression
Pressure ulcer	5–20	Depression, agitation
Moderate to severe obesity	15–30	Depression, anxiety, sleep disturbance
Inappropriate medication	10–50	Cognitive impairment, agitation
Frailty	20–40	Cognitive impairment, depression
Malnutrition (including vitamin deficiency, especially vitamins B_{12} and D)	30–60	Depression, agitation, cognitive impairment
Obstructive sleep apnea	5–15	Cognitive impairment, insomnia
Hypoglycemic episodes due to overtreatment of diabetes	5–10	Anxiety, cognitive impairment, delirium
Hyponatremia	5–10	Cognitive impairment, agitation
Under- or overcorrection of hypothyroidism	5–10	Depression, anxiety, agitation, insomnia

are underdetected in a substantial number of LTC residents, especially residents who have MNCD (Koch et al. 2005). Arthritis and osteoporosis are also often undetected and undertreated. Frequently, the work-up for infection is inadequate, and in 25–75 percent of the cases, the antibiotic chosen is inappropriate. Asymptomatic bacteriuria and pyuria are often inappropriately treated with antibiotics.

A substantial proportion of LTC residents are being prescribed medications that are inappropriate and are responsible for considerable excess physical and mental health morbidity (American Geriatrics Society 2015; Kotlyar et al. 2011). Routine use of opioids to manage chronic noncancer pain is common among LTC residents (point prevalence 20–40 percent) and as-needed use of opioids for chronic noncancer pain management is even higher (40–70 percent). The use of multiple opioid medications is also prevalent (5–15 percent). Opioid use to manage chronic noncancer pain is often inappropriate and carries substantial risks of delirium, falls, daytime sedation, decline in ADLs, irritability, severe constipation, and memory impairment. Use of more than one drug with significant anticholinergic activity is also high (point prevalence 30–60 percent) and carries risks of memory impairment, delirium, and falls.

Nearly 25 percent of older adults will spend some time in a nursing facility, typically for rehabilitation after a hospitalization (Sanford et al. 2015). The majority will subsequently return home, but a significant number (5–7 percent) are likely to require continued care in a LTC facility. Many LTC residents develop acute physical health problems requiring hospitalization and typically return to the LTC facility for rehabilitation. Delirium and depression are even more prevalent among residents receiving rehabilitation than among LTC residents (Hui and Sultzer 2013).

More than 20 percent of older adults die in LTC facilities (Institute of Medicine 2014; Teno et al. 2013). Palliative and end-of-life care for LTC residents is inadequate, and many residents spend their last days or weeks in substantial suffering due to poorly managed agitation, depression, and/or pain. LTC facilities must be able to provide excellent palliative and end-of-life care for all residents, and addressing mental health is an essential component of such care (Desai and Grossberg 2011).

Table 1.4 Common Advanced Physical Health Problems among Long-Term Care Residents and Associated Mental Health Concerns

Common Advanced Physical Health Problem (point prevalence)	Key Associated Mental Health Concern	Key Commonly Used Psychotropic Medication to Avoid or Use with Extra Caution
Cerebrovascular accident(s) (10–30)	Cognitive impairment, depression	Antipsychotics
Coronary heart disease (20–40)	Depression	Tricyclic antidepressants
Heart disease with prolonged QTc interval	Depression	Citalopram, ziprasidone
Congestive heart failure (10–30)	Depression	Tricyclic antidepressants
Chronic obstructive pulmonary disease (10–30)	Anxiety, depression	Benzodiazepines
Stage 4 or higher chronic kidney disease (10–30)	Depression, chronic pain	Lithium, gabapentin
Morbid obesity (10–20)	Depression	Olanzapine, quetiapine, valproate, mirtazapine
Obstructive sleep apnea (5–20)	Depression, insomnia	Benzodiazepines
Diabetes (10–30)	Depression, cognitive impairment	Olanzapine, quetiapine
Hip fracture(s) (10–20)	Depression, chronic pain	Benzodiazepines
Epilepsy (5–15)	Cognitive impairment, depression	Bupropion

Family caregivers' reasons for admitting someone to a LTC facility include the resident's MNCD-related behavior (most common); the caregivers' health; and the resident's incontinence, need for more skilled care, and need for more assistance (Balestreri, Grossberg, and Grossberg 2000; Brodaty et al. 2014). These factors are usually evident in the year before admission. The number of people who have MNCD is increasing, and physicians have recommended that they move into a LTC facility for one or more of the following reasons: safety (administration of medications, regular intake of meals, safe wandering areas), medical problems (incontinence), and psychosocial issues (socialization to address loneliness, meaningful activities to address boredom, insomnia, and agitation). Many other older adults move to a LTC facility because of frailty, a stroke, or other serious medical condition.

Most LTC facilities are not designed to allow plenty of natural light to come in, nor do they have safe areas for wandering. Excessive nighttime noise, poor lighting, and limited exposure to plants and nature pose significant harm to residents' emotional and spiritual well-being. Most LTC staff members do not have adequate education and training in understanding and managing behavioral and psychological symptoms associated with MNCD, nor do they receive adequate support from administrative leadership. Stress and burnout are ubiquitous among LTC staff, and staff turnover in LTC is among the highest in all health care institutions. This is primarily because staff members are often underpaid, overworked, and underappreciated.

Given the complexity and frailty of LTC residents and the enormous psychosocial and environmental issues, meeting the mental health needs of these residents presents enormous challenges for the already strained LTC health systems.

Evidence-Based Psychiatric Approaches

Our health care system is currently failing to meet the mental health needs of LTC populations (Institute of Medicine 2014; Prince, Prina, and Guerchet 2013; World Health Organization 2015). Primary reasons for this are underdetection, undertreatment, and mistreatment of psychiatric disorders (Desai and Grossberg 2017). This is happening despite increasing evidence from randomized-controlled trials and outcomes from real-life treatment that residents who receive appropriate treatment for psychiatric disorders have improved daily functioning and quality of life (American Geriatrics Society 2011; Cummings et al. 2015; Kales, Gitlin,

and Lyketsos 2014; Kopke et al. 2012; Porteinsson et al. 2014; Poudel et al. 2015; Testad et al. 2014; Mulsant and Pollock 2015). (See Tables 1.1, 1.5, and 1.6.) Strength-based, personalized, psychosocial sensory spiritual environmental initiatives and creative engagement (SPPEICE) are sufficient to treat mild to moderately severe mental health problems, and judicious use of evidence-based psychotropic medication may be necessary in addition for severe mental health problems and for chronic mental illness (Kales, Gitlin, and Lyketsos 2014). It is time we champion changes in mental health care services so that LTC facilities can provide integrated care that uses evidence-based psychiatric approaches to prevent and treat psychiatric disorders with close collaboration between the primary care team and mental health professionals.

Making a Case for Routine Availability of High-Quality Comprehensive On-Site Mental Health Services

LTC populations must be able to receive excellent mental health care as an integral part of overall care (Desai and Grossberg 2017; Streim 2015). Primary care clinicians often find the diagnosis and management of psychiatric disorders in LTC populations daunting even with all the practice guidelines available from various organizations regarding evidence-based psychiatric approaches (American Geriatrics Society 2011; Canadian Coalition for Seniors' Mental Health 2014). This is not surprising, given the complexity of psychiatric disorders among residents who are already severely compromised by advanced physical health problems, cognitive deficits, sensory deficits, and limitations in performing ADLs. Hence, the availability of a team of mental health professionals who have expertise to provide such complex care is essential. Additionally, psychiatric mismanagement is prevalent and often catastrophic for residents and medico-legally expensive for the facility. (See Table 1.1.) Input from mental health professionals who have expertise in LTC psychiatry often changes understanding of the resident's emotional distress, mental health diagnosis, treatment, and outcome (Poudel et al. 2015; Desai and Grossberg 2017; Streim 2015). Psychiatric disorders are often chronic and disabling, and on-site mental health professional services can improve care. Last but not least, residents and family members might insist that residents deserve treatment on site by experts in the condition because of the considerable burdens posed by transportation of severely disabled and frail residents to an outpatient mental health clinic. Hence, on-site availability of mental health professionals who have expertise in LTC psychiatry is essential to meet the mental health needs of vulnerable LTC populations.

Mental health professionals include geriatric psychiatrists, adult psychiatrists, psychiatric nurse practitioners and psychiatric physician assistants, neuropsychologists, gerontologists, psychologists, and social workers. See Box 1.1 for common reasons for seeking help from a mental health professional who has expertise in LTC psychiatry. Only geriatric psychiatrists receive comprehensive training in LTC psychiatry. Other mental health professionals need to have training in LTC psychiatry before working in LTC.

Residents in LTC facilities live with each other in close settings 24 hours a day, seven days a week. They have their own rooms (often shared with another resident) but come together for meals, socializing, activities, and entertainment. These are small, intense communities, and LTC staff will need to manage the associated conflicts and disputes by conflict resolution in order to maintain the residents' autonomy yet keep control of the situation. Mental health professionals can guide LTC staff in creative ways of addressing conflict (between residents, between resident and family, and between resident/family and staff) to prevent unnecessary or excessive emotional distress of residents and staff burnout. This is especially important in conflict situations involving residents who have personality disorder.

It is not uncommon to find a married couple residing in a facility, and this situation comes with its unique set of psychosocial challenges. Typically, one spouse is cognitively impaired and the other is healthier but has chosen to live in the facility so as to continue to live with the spouse. For the cognitively impaired spouse, psychosocial approaches focus on how to prevent further decline, and for the healthier spouse, professional caregivers should help the person cope with loss, grief, stress, and situational depression. Mental health professionals can guide LTC staff in the prevention of mental health problems between spouses living in LTC.

The psychosocial well-being of many LTC residents depends considerably on the well-being of

BOX 1.1 Mental Health Team Members and Key Reasons for Seeking Their Help

Mental Health Team Member	Key Reasons for Seeking Help
Psychiatrist	Assess and manage risk for suicide
	Assess and manage risk for violence
	Consult regarding psychiatric emergencies
	Assess and manage psychiatric symptoms*
	Assess capacity to make health care decisions
	Assess need for palliative care
	Consult regarding optimizing brain function
	Educate and train staff**
	Guide facility leadership toward person-centered care (PCC) culture
	Consult for gradual dose reduction of psychotropic medication (PM)
	Consult for addressing high-risk PMT
	Consult for reducing use of antipsychotic medication
	Design programs to diminish caregiver burnout
Neuropsychologist	Clarify severity and etiology of cognitive decline
	Assess capacity to make health care decisions
	Consult regarding optimizing brain function
Gerontologist/psychologist	Provide individual psychotherapy
	Provide group psychotherapy
	Aid staff-resident conflict resolution
	Educate and train staff
	Design programs to diminish caregiver burnout
Social worker	Provide individual psychotherapy
	Provide family therapy and conflict resolution
	Provide group psychotherapy
	Aid staff-resident conflict resolution
	Educate and train staff
	Design programs to diminish caregiver burnout
Psychiatric nurse	Educate and train staff
	Teach relaxation strategies to residents and staff
	Design programs to diminish caregiver burnout

* Psychiatric symptoms include but are not limited to the following: cognitive decline, depression, anxiety, insomnia, hypersomnia, psychotic symptoms, suicidal ideas, self-harmful behavior, homicidal ideas, agitation, verbal and/or physical aggression, sexually inappropriate behavior, addiction problems, and pain.

** Topics for staff education and training include: importance of validating residents' experiences and inquiring about and routinely incorporating their perspectives into care plans; psychosocial environmental approaches to manage behavioral symptoms of MNCD; nondrug management of pain; nondrug management of sexually inappropriate behavior; sleep hygiene and other nondrug approaches for management of insomnia/sleep disorder; relaxation strategies, mindfulness-based approaches; monitoring adverse effects of PMT; Beers list of drugs that are inappropriate for LTC populations; assessment of risk for suicide; assessment of risk for violence; strategies to de-escalate resident aggression and prevent resident-to-resident aggression.

family and professional caregivers. Family members (especially a spouse) may not be able to spend enough time with the resident, adding to the resident's losses. Family members may themselves be stressed, experience guilt and anxiety, and be depressed. These negative emotions can have a negative effect on the resident, either directly (e.g. resident feels guilty and feels a burden) or indirectly (e.g. family spends less time with the resident). Many family caregivers continue to carry a substantial burden of caregiving even after the loved one enters LTC. Caring for a loved one who resides in an LTC facility can be rewarding, but also overwhelming at times. Factors that are stressful for family caregivers of LTC residents are different in