



## Conducting Mental Assessments

*Many patients with mental illnesses enter long term care facilities without ever having been diagnosed.*

**W**HILE MANY PEOPLE WITH mental illness have been diagnosed prior to entering a long term care facility—enabling providers to plan their care—others who exhibit symptoms that meet the criteria for various mental illnesses check into assisted living or nursing facilities without prior diagnoses.

In some cases patients' problems are masked because too few primary care physicians have the training or time needed to identify the signs and symptoms of mental illness. But another reason may be the illnesses themselves: depression, anxiety, or dementia can muddle the mind enough that the individual is no longer able to articulate what's wrong or even think to get help for the illness.

In addition, the lack of collaboration between agencies and coordination among primary care and other service providers, fragmented and inadequate funding, service gaps, and shortages of people trained in geriatric mental health care have been barriers to receiving such care. And many studies have shown that few medical or other health-related curricula provide adequate, or any, training on the mental health needs of the elderly, according to a report from the Department of Health and Human Services' Administration on Aging.

Patients with cognitive impairments can be especially challenging to assess. "A major challenge is separating dementia, general confusion, and forgetfulness from a more structured disease such as psychosis—paranoia, hallucinations, delusions," says Brad

Whitney, MD, director of senior health at Spartansburg Regional Hospital, Spartansburg, S.C. "Someone may see their mother at the door, but instead of psychosis it's just that poor lighting made someone else look like their mother."

### PREVALENCE OF MENTAL ILLNESS AMONG NURSING FACILITY PATIENTS

| Disorder                      | *SNF Patients (%) |
|-------------------------------|-------------------|
| Anxiety Disorders             | 25-50             |
| Generalized anxiety disorder  | 17-21             |
| Mood Disorders                |                   |
| Major depression              | 12-53             |
| Dysthymia                     | 17-30             |
| Bipolar                       | 2-12              |
| Psychotic Disorders           | 10-16             |
| Schizophrenia                 | 12-15             |
| Severe Cognitive Impairment   | 50-90             |
| Dementia with a mood disorder | 10-25             |
| Dementia with delirium        | 22-89             |
| Dementia with psychosis       | 22-60             |

\*Variance in the right-hand column is due to the broad range of studies used to compile this chart.

Source: A compilation of various recent studies published in the *Journal of Neurological Neurosurgical Psychiatry*, the *American Journal of Psychiatry*, the *Journal of the American Geriatrics Society*, the *International Journal of Geriatric Psychiatry*, and the *Journal of Neuropsychiatry and Clinical Neurosciences*, among others.

### Assessment And Diagnosis

For patients who can't articulate their feelings, Lichtenberg suggests a non-verbal assessment method called "visual analogues." In this method, patients can point to a picture of a face that is expressing an emotion similar to what the patient is feeling.

Also, patients with moderate cognitive impairment can answer close-ended questions ("Do you often feel

sad? Yes or no?") more easily than open-ended ones ("How would you describe your mood lately?").

When seeking to separate mental illness from other common conditions of elderly patients entering a nursing facility (short-term memory loss, dementia, confusion), it is important to get an accurate history, say from mental health program managers, especially for distinguishing between somatic and mental disorders.

Interviewing the patient is an important first step in this process, but that alone isn't enough to get an accurate history. Many experts say that the elderly are reluctant to report symptoms of mental illness, especially symptoms clearly beyond ordinary experience such as hallucinations. Also, short-term memory declines with age. Especially in the case of significant cognitive impairment, an accurate history can only be obtained by gathering medical charts that precede the patient's admission and by interviewing family members before and after admission.

### Search For Clues

Assessment and diagnosis of mental disorders in older people can be particularly difficult, according to the Administration on Aging. Seniors are unlikely to come out with bold, clear statements like, "I'm depressed, and I want an antidepressant." Instead, they may mention things that indicate apathy for activities they previously enjoyed, reluctance to leave their rooms, or somatic symptoms—fatigue, aches and pains, gastrointestinal prob-

lems—that may mask psychopathology. Identifying a mental disorder requires a fair amount of reading between the lines and then drawing out the information necessary to determine whether a mental illness exists, say the authors of a recent study of the diagnostic difficulties published in *The Gerontologist*

**Standards For Assessment**

A task force of the American Psychological Association, called Psychologists in Long Term Care (PLTC), has put together a set of standards for mental health care programs in long term care facilities, stressing the importance of psychological interventions before resorting to medications and addressing the delicate balance of treating and caring for patients with an array of medical, cognitive, and psychological disorders.

The PLTC guidelines suggest that mental status be assessed through a combination of clinical interviews; mental-status questionnaires; and information obtained from family, staff, or other sources. Testing should include an assessment of overall daily functioning and self-care skills; a comprehensive cognitive assessment; and psychological testing that assesses personality, emotional functioning, psy-

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chopathology, and mental status. Some experts recommend assessments that involve standardized evaluations of patients' role-playing of "real life" situations. This kind of testing combines reliability and validity with practicality, giving it an advantage over self-reporting—and even reports from collateral sources such as family members.

Collateral sources' information "may be biased due to social ideas of desirable behavior and lack of insight, and clinicians' ratings may be based on collateral reports or very limited observation," says Elizabeth Twamley of the Veteran Affairs San Diego Healthcare System, La Jolla, Calif.

Twamley studied assessment tests for elderly people in long term care and

other settings and recommends the University of California, San Diego, Performance-Based Skills Assessment. The assessment is more sensitive to psychiatric symptoms, she says, than the Mini-Mental State Examination or the Mattis Dementia Rating Scale, both of which are widely used.

The test determinant of behavior is cognitive functionality, say many experts. But merely labeling a cognitive deficit "dementia" or even "Alzheimer's" is too nonspecific, they say. It's essential that cognitive functioning be assessed both in terms of specific impairments and spared functions, since these will have an important bearing on the success of any care management strategy.

Many geriatric psychiatrists highly recommend neuropsychological testing to determine if dementia and depression are both present, if a patient's sudden cognitive decline or change is due to delirium, if the level of care needed is beyond the facility's resources, or to determine competency.

Some consider a full neuropsychological evaluation essential for treatment planning, while others say that it is time-consuming and not warranted in every case of inappropriate behavior. Instead, they say a neuropsychological screening battery, which takes about an hour to administer, provides enough information for most care plans.

The battery assesses various aspects of the patient's orientation, attention, memory capacities, language skills, constructional abilities, motor and sensory-perceptual functions, and abstract reasoning.

**Assessment, Documentation**

PLTC guidelines state that the person in charge of a facility's mental health program should perform timely and clear documentation of each patient's diagnosis, treatment plan, progress, and outcome in accordance with current ethical and legal standards.

Patients who have been identified by a staff member as possibly in need of

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mental health treatment should receive a systematic behavioral assessment, the guidelines say. In addition, significant changes in a patient's mental condition are required by law to be reported to the state mental health agency.

A behavioral assessment begins with obtaining a detailed description from the referring staff member of the specific problem behaviors exhibited by the patient and, if possible, the events that immediately preceded and followed these behaviors, according to "Practical Psychiatry in the Nursing Home: A Handbook for Staff," published by Hogrefe and Huber.

After that, occurrences of the described behavior should be systematically observed, documented, and analyzed, including the stimuli that elicited the behavior described in the referral and the events following that behavior that may be reinforcing its continuance, according to a study published by Lichtenberg in *The Gerontologist*

### Types Of Documentation

Depending on the severity of the behavior, different intensity levels of documentation can be used. The most intensive—generally only appropriate when a highly specific analysis is required—is called "continuous recording," according to the book, "Practical Psychiatry In The Nursing Home." This entails writing down everything the patient does or says. "Duration recording" is continuous documentation for the length of time that the behavior lasts. "Interval recording" is done at set intervals, such as every five minutes or every half hour.

The recording individual writes specifics of any incidences of the behavior that occurred during that time period, the manual says.

The information gleaned from these records facilitates a care plan with behavioral interventions most likely to increase the frequency of positive behaviors and decrease those that are

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negative. The initial period establishes the frequency and severity of the problem and provides a baseline against which any changes can be measured.

The assumption is that every identified behavior has a triggering event and an event that encourages its repetition.

When an episode occurs, a nurse or the caregiver involved in the incident should write up a brief report that includes the date and time; what happened immediately before the behavior ("The CNA entered the room to help the patient get dressed"); a description of the patient's specific behavior, including direct quotes if possible; and a description of what happened immediately afterward (for example, exactly how she responded).

It's important that specific behaviors be described, rather than using general terms like "aggression," "dependence," or "agitation," which are too vague when analyzing an individual's psychological state. Instead of aggression, specific behaviors such as spitting or hitting should be described; instead of "dependence," a description like "refusal to feed self;" instead of "agitation," perhaps "wringing hands" or

"pulling own hair," the psychiatry manual suggests.

Unfortunately, the triggering event isn't always observed. It may have been something the patient thought, for example, which is why the assessments of cognitive function and past psychological history are so important and can help the mental health professional or nurse figure out what might have happened. ■

### For More Information

- AARP's Coalition on Mental Health and Aging (focusing on policy and reimbursement issues): [www.aarp.org](http://www.aarp.org).
- American Association for Geriatric Psychiatry: [www.aagpgpa.org](http://www.aagpgpa.org).
- American Foundation for Suicide Prevention: [www.afsp.org](http://www.afsp.org).
- American Society on Aging: [www.asaging.org](http://www.asaging.org).
- Anxiety Disorders Association of America: [www.adaa.org](http://www.adaa.org).
- Center for Elderly Suicide Prevention and Grief-Related Services, Goldman Institute on Aging, 3626 Geary Blvd., San Francisco, CA 94118, (415) 750-4180 ext. 230.
- International Psychogeriatric Association: [www.ipa-online.org](http://www.ipa-online.org).
- Internet Mental Health: [www.mentalhealth.com](http://www.mentalhealth.com).
- Mental Health Infocource: [www.mhsource.com](http://www.mhsource.com).
- National Alliance for the Mentally Ill: [www.nami.org](http://www.nami.org).
- National Depressive and Manic Depressive Association: [www.ndmda.org](http://www.ndmda.org).
- National Institute of Mental Health: [www.nimh.nih.gov](http://www.nimh.nih.gov).
- National Mental Health Association: [www.nmha.org](http://www.nmha.org).
- Psychiatry Matters (daily news on psychiatric issues): [www.psychiatrymatters.md](http://www.psychiatrymatters.md).
- Psychosis InSite (psychosis research and education): [www.mirecc.org](http://www.mirecc.org).