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# Preparing Long-Term Care Staff to Meet the Needs of Aging Persons with Serious Mental Illness

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## Abstract

**Objectives:** Individuals with serious mental illness (SMI; schizophrenia spectrum disorders and affective psychoses) are increasingly aging into older adulthood and are overrepresented in residential long-term care settings. The present study aimed to examine the preparedness of staff in these settings to care for individuals with SMI.

**Design:** A multidisciplinary U.S. Department of Veterans Affairs (VA) workgroup of professionals with expertise in geriatric mental health collected voluntary feedback via online questionnaire, as part of a quality improvement project.

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**Setting and Participants:** Respondents were mental health providers (N=51) embedded in VA nursing homes, called Community Living Centers (CLCs).

**Measures:** The questionnaire contained multiple-choice, Likert scale, and open-ended questions regarding the opportunities and challenges associated with caring for Veterans with SMI in CLCs.

**Results:** Respondents identified a lack of training of front-line staff as a key challenge in providing high quality care to residents with SMI. Specifically, respondents indicated a need to increase staff knowledge about SMI symptoms and diagnoses, to improve staff communication and interactions with residents with SMI, and to decrease mental illness stigma among staff.

**Conclusions and Implications:** The present study revealed significant areas of training need for front-line staff in nursing homes. Many perceived staff training needs overlap with the knowledge and skill set required to provide high quality dementia care. Integrating training regarding the care of residents with SMI into dementia care training efforts may be a fruitful future direction. Strategies for this and a suggested curriculum are provided.

## Keywords

serious mental illness; nursing homes; assisted living; long-term care; staff training

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Individuals with serious mental illnesses (SMI; here defined as psychotic disorders including schizophrenia, schizoaffective disorder, bipolar disorder, and depression with psychosis) are aging in unprecedented numbers, and have complex care needs across cognitive, medical, and psychosocial domains.[1] These individuals are overrepresented in nursing homes[2, 3] and assisted living communities.[4, 5] Compared to individuals with other chronic mental health conditions, persons with SMI living in the community are at elevated risk for early institutionalization.[6, 7] In fact, the majority of new nursing home admissions who have SMI are younger than age 65,[8] creating a unique and complex nursing home subpopulation. Many long-term care settings lack trained mental health staff and may be ill-suited to provide comprehensive, recovery-oriented (i.e., holistic and person-centered) behavioral health services for residents with SMI.[9, 10] Strategies to train long-term care staff to care for residents with SMI are needed.

The deinstitutionalization movement and rapid closure of state psychiatric hospitals in the 1960s and 1970s led to rapid growth of admissions of individuals with SMI to nursing homes, even those who did not qualify medically for skilled nursing care.[10] To counter this, in 1987, the Omnibus Budget Reconciliation Act (OBRA) was passed, which included mandated screening for SMI among new admissions to all U.S. federally-certified nursing homes (PASRR; Pre-Admission Screening and Resident Review). Although compliance with PASSR was variable,[11] the percentage of individuals with SMI in U.S. nursing homes nationally decreased on average between 1985 and 1995.[12]

The prevalence of SMI in nursing homes and assisted living communities varies significantly by state and facility.[2-4] Data from Minimum Data Set assessments indicated that the average proportion of residents with schizophrenia or bipolar disorder in nursing homes grew from 6.4% to 8.3% between 2000 and 2008, and in 2008, the five percent of facilities with the highest proportion of SMI residents had at least 20%.[13] In the U.S.



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Department of Veterans Affairs (VA), nursing homes are known as Community Living Centers (CLCs), which provide long-stay and short-stay skilled nursing, rehabilitation and palliative care. In one study using VA data, the national prevalence of schizophrenia, bipolar disorder, and other psychotic disorders in CLCs rose from 29.4% to 43.8% between 1999 and 2007, though prevalence varies significantly by facility.[14] VA CLCs are not required to conduct PASRR screenings, but they do require that residents have a skilled nursing or functional care need. In both community and VA long-term care communities, residents with SMI likely include some who require the level of care provided and others who would be better served in a less restrictive setting.[14-16]

Individuals with SMI are more likely to be admitted to nursing homes with poorer quality of care indicators.[17, 18] Having a high proportion of SMI residents is associated with inferior quality of care for all residents, including higher rates of hospitalization,[13] untreated depression, incontinence without a toileting plan, and pain,[19] indicating that attending to the complex care needs of residents with SMI may stretch limited resources in these facilities. In addition, residents with SMI may receive poorer quality of care than other residents, including lower rates of completed advanced directives[20] and inadequate pain assessment/ treatment, even when controlling for facility level characteristics.[21, 22]

Long-term care residents receive a median of approximately 4 hours of contact from nursing assistants and nursing staff each day.[23] Given the pivotal role of positive social engagement in influencing SMI outcomes, [24] long-term care staff can engender hope and empowerment among this vulnerable resident population. Unfortunately, long-term care staff training curricula most often do not include information regarding caring for residents with SMI,[25] state regulations frequently do not stipulate requirements for nursing home staff on this topic,[26] and training on this topic is not a requirement for nursing staff in VA CLCs. Without training, nursing home and assisted living staff may be relying on common public misperceptions of these disorders, which are generally inaccurate and stigmatizing.[27]

Few studies have examined the perspectives of long-term care staff on working with residents with SMI. In one such study of community nursing homes in Florida, staff and administrator surveys, interviews, and focus groups[28] revealed that need for staff training on this topic was a ubiquitous recommendation. Staff members expressed fear of aggressive behavior from residents with SMI, who tended to be younger and stronger than other nursing home residents in the milieu, and shared their perspectives that caring for residents with SMI took time away from their ability to care for other residents and contributed to staff burnout and turnover.

The perspectives of staff members in VA CLCs regarding the care of residents with SMI have not been previously published. CLCs are different from most community nursing homes and assisted living communities, in that VA policy requires every CLC to have an integrated psychologist, as well as access to geriatric psychopharmacology treatment.[29] Given that VA CLC mental health providers, i.e., psychologists and psychiatric providers, are both trained in mental health care and are familiar with the CLC milieu, they provide a unique source of data on staff training needs. The present study examined the perspectives of

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VA CLC mental health providers regarding the most pressing training gaps for front-line staff, with an eye to informing future training interventions.

# Method

The VA Office of Mental Health and Suicide Prevention convened a workgroup to examine staff needs and make recommendations for providing high quality care for residents with SMI in CLCs, comprised of interdisciplinary VA staff from psychiatry, psychology, neuropsychology, social work, nursing, and research. SMI is defined variably in the literature; for the current project, SMI was defined as psychotic disorders, including schizophrenia spectrum disorders, bipolar disorder, depression with psychotic features, and other psychotic disorders. A more restrictive definition was selected because, over and above a diagnosis of other chronic mental health conditions, psychotic disorders confer particularly elevated risk for early institutionalization in long-term care settings.[6, 7] In addition, residents with psychotic disorders are a unique population of nursing home residents: they are often younger and may present with psychiatric symptoms such as hallucinations, delusions, or odd/eccentric behaviors that are particularly challenging or alienating to nursing home staff.[8, 28]

All workgroup members had research or clinical expertise in geriatric mental health and/or SMI; the majority were mental health providers in VA CLCs. The workgroup convened monthly in 2017 and developed an online questionnaire to obtain voluntary feedback from CLC mental health professionals. The questionnaire was adapted in part from an earlier VA operational survey of CLC nurse leaders about a range of CLC care services. A link to the questionnaire, inviting voluntary and anonymous participation, was sent electronically to members of a VA national listserv for CLC mental health providers in February and March 2017. Questions focused on a wide range of topics pertaining to the care of residents with SMI in CLC settings, with multiple-choice, Likert scale, and open-ended questions.

## Analysis

Frequencies were calculated for multiple-choice and Likert-type scale questions on the following topics: satisfaction with quality of care for residents with SMI, frequency of concerns about care for these residents, staff knowledge, skills, and attitudes regarding the care of residents with SMI, staff experiences with training in SMI, importance of additional staff training, most important topics for training, and preferences for training modalities. Using an inductive content analysis approach[30], we examined responses to the open-ended question, “What do you perceive as the greatest challenge to caring for residents with SMI on CLCs?” to identify categories of topics that could potentially be addressed through training.

# Results

Fifty-one people responded to the questionnaire, representing 24% of those on the listserv distribution list at the time of the request for feedback; forty-one of these completed the entire questionnaire. Responses were primarily from CLC-based psychologists (86%), with fewer psychiatrists (10%), and nurses (4%), roughly approximating the proportion of these

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professions subscribed to the email listserv. Approximately half (49%) of respondents reported working full-time in the CLC. Estimates of the percentage of residents with SMI in the CLCs where respondents worked were 1-20% (44% of respondents), 21-40% (42% of respondents), and >40% (13% of respondents).

In Table 1, questionnaire items and response frequencies to Likert-type scale questions regarding satisfaction with quality of care and staff knowledge and experience are displayed. Fourteen percent of respondents indicated that they believed CLC staff have the necessary knowledge and skills to care for residents with SMI. Eighty percent stated that less than a third of staff had received training regarding care for residents with SMI. Eighty-eight percent reported that it was very or extremely important for staff to receive additional training on this topic. The majority of respondents (63%) believed that working with residents with SMI was contributing to staff burnout. Thirty-nine percent of respondents believed that staff were fearful or uncomfortable with interacting with residents with SMI, and 43% of respondents reported that staff voice displeasure about having to work with residents with SMI.

In Table 2, the most common topics for training endorsed by respondents, and their preferred options for training delivery are displayed. Understanding the symptoms of SMI and managing challenging behaviors were almost unanimously endorsed by respondents as important topics for training; in addition, respondents preferred on-site trainings to web- or paper-based trainings.

In addition, respondents were asked in an open-ended question what they perceived as the greatest challenge(s) regarding care for persons with SMI in CLCs. Forty-one people responded, and approximately half (n=22) mentioned the lack of training on SMI as an issue. These training related responses were categorized into four content areas. (1) Most frequently cited was lack of staff knowledge and experience working with residents with SMI (e.g., "Lack of knowledge for staff… Nursing staff don't work with veterans with SMI on a regular basis”). (2) Responses addressed the need for improvement in staff interaction and communication with residents with SMI (e.g., "Need for staff to approach residents in a way that does not trigger maladaptive behaviors"). (3) Mental illness stigma and negative attitudes about residents with SMI were also mentioned (e.g., "Stigma… rigidity in thinking about SMI" and "Taking personal offense to negative comments that these patients… verbalize"). (4) Several comments addressed how best to care for residents with SMI within a CLC environment, alongside individuals with dementia (e.g., "Setting appropriate limits and safeguards for unsafe behavior when also working with individuals with dementia in the same setting who require a more flexible, accommodating approach").

## Discussion

Residents with SMI are overrepresented in long-term care settings. Though some of these residents would be better served in less restrictive settings, a subset of individuals with SMI do indeed, require skilled nursing care, and that number will likely grow as this population ages. The present inquiry revealed important information about the training needs of front-line nursing home staff regarding the care of residents with SMI, from the unique

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perspectives of mental health providers working in VA CLCs. Notably, even in a long-term care setting that includes integrated mental health staff, respondents identified a lack of training of front-line staff as a key challenge in providing high quality care to residents with SMI. Although overall, most respondents (63%) were at least satisfied with the quality of care provided to these residents, they also reported that concerns about the care of residents with SMI arise as a matter of routine. These findings suggest that front-line staff are not negligent or incompetent, but simply need tools and support. Specifically, respondents indicated a need to increase staff knowledge about SMI, improve staff interactions and communication with residents with SMI, decrease mental illness stigma among staff, and to help staff understand how to care for residents with SMI alongside residents with dementia and other diagnoses in a long-term care milieu.

The need for more and better training regarding behavioral health issues for staff in long-term care facilities has been highlighted repeatedly for decades.[31] The existing literature mostly focuses on training in dementia care, including management of behavioral symptoms, responding to neuropsychiatric symptoms, and strategies for therapeutic communication;[32-34] notably, these topics overlap significantly with training gaps identified in the present inquiry. Our findings support the need for development of an integrated behavioral health curriculum for front-line nursing home staff that not only focuses on care for residents with dementia but is inclusive of SMI and recovery. (See Table 3 for list of key content and resources regarding a curriculum on the topics of SMI and recovery).

Two recent studies have pilot tested example curricula regarding SMI and recovery for direct support staff in nursing homes[35] and assisted living communities[36] with positive outcomes. These curricula emphasize person-centered, compassionate care, strategies for effective and therapeutic communication, and principles of behavioral management. An emphasis on destigmatization of mental illness, "myth-busting", and the recovery model are also key components. These curricula also differentiate SMI from dementia. For example, although SMI is also characterized by significant cognitive impairment, individuals with SMI typically do not exhibit the profound impairments in recall memory or generally deteriorating course typical of individuals with dementia.[37] Finally, curricula could also include strategies from the growing literature on combined psychiatric and somatic interventions for individuals with SMI.[38]

In addition to employing appropriate curricula content, effective training models are required. A growing literature on dementia training programs[32-34] indicates positive effects for staff knowledge, skills, satisfaction, and turnover, and resident outcomes; by integrating training regarding SMI into these efforts, one could extend these gains. Although respondents in the present report exhibited a preference for in-person trainings as opposed to web-based trainings, literature reviews of dementia training programs[32-34] have found that web-based delivery of information is an effective way to train busy staff across shifts. To facilitate transfer of knowledge to practice, training models which include ongoing "on-the floor" reinforcement are necessary. Thus, a combination of web-based delivery of information, in-person training, and ongoing in-person supervision and feedback may be required.

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Finally, respondents in the present inquiry indicated that working with residents with SMI engendered fear, discomfort, and burnout among front-line staff. Thus, focusing on promoting staff buy-in, addressing mental illness stigma, and being prepared for staff turnover are key considerations. In the dementia training literature, “train-the-trainer” approaches have been used to this end. For example, in the STAR-VA intervention program for managing behavioral distress among CLC residents with dementia, “Behavioral Coordinators” and “Nurse Champions” are trained to work with the CLC team on behavioral care planning, and may also provide regular retraining to address staff turnover[39]. In addition, research on reducing stigma related to ageism, disease, and medical illness in long-term residential care[40, 41] may offer a framework for reducing stigma related to mental illness in these communities.

Efforts to destigmatize mental illness and make behavioral health care a standardized structural component of care are needed. This could start with a consideration of training requirements regarding SMI for staff in long-term care settings. Notably, as of 2014, the Joint Commission requires that staff at accredited nursing care centers have the skills and training to assess and provide care to residents with memory impairment,[42] but has no such requirement regarding the care of residents with SMI. Additionally, it may be necessary to rethink how nursing homes are staffed, with considerations for staffing levels considering the presence of residents with behavioral health needs. In addition, specific recruitment efforts could be targeted at hiring nursing home staff with specialized training in behavioral health care. Promotions could be offered to CNAs or nurses willing to obtain this specialized knowledge. One way to structure these efforts might be to implement specialized mental health recovery units within long-term care communities, with specialized staff trained to meet the needs of this population. Whether this practice could improve quality of care for these individuals has not been evaluated; this is an important area for future research inquiry.

Evidence indicates that, regarding destigmatizing mental illness, contact-based education programs in which trainees interact with individuals with mental illness diagnoses, are most effective.[43] Thus, long-term care facilities could draw from the deep well of resources of mental health consumer advocacy organizations, such as the National Alliance for Mental Illness (NAMI), to provide contact-based staff education at their facilities. Indeed, there is a growing movement of integration of peer support, or support from individuals with their own lived experience of mental illness, into traditionally medical settings such as primary care;[44] options to integrate peer support into long-term care settings could also be considered.

Notable limitations of this project included a low response rate from the broader group of CLC mental health providers. It is unknown how those who responded differed from those who did not, and it may be that those who did respond were providers for whom this topic was most salient. In addition, the questionnaire used was developed for the purposes of a quality improvement project; psychometric data are not available. Finally, respondents were drawn only from within the VA system, which could limit generalizability.

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### Conclusions and Implications

Older adults with SMI are a neglected population with complex care needs, but with appropriate support and recovery-oriented treatment, have the potential to achieve a high quality of life.[45] The present inquiry highlights the need for increased attention to the training of staff in long-term care settings in the care of adults with SMI. The unique perspectives of mental health providers working in a geriatric setting makes a valuable contribution to this area of study. Importantly, we note agreement among diverse stakeholders regarding the importance of nursing home staff training on SMI. In our experience, front-line staff members are eager for knowledge on this topic to improve the quality of care they provide. Just as has been shown for individuals with dementia,[46] caring for residents with SMI could provide a unique and empowering opportunity for long term care staff to promote substantial improvements in quality of life through provision of compassionate, person-centered, recovery-oriented care. With the need to improve care for residents with SMI clearly recognized and staff indicating their desire for training, the impetus falls on administrators and policy-makers to move the agenda forward.

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Summary/highlights: Staff in nursing homes need specialized training to provide high-quality care to residents with serious mental illness (SMI). Integrating training regarding SMI into dementia training curricula is a promising future direction.

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## Table 1.

Responses Regarding Quality of Care and Staff Preparedness to Care for Residents with SMI

| | **Very dissatisfied** | **Dissatisfied** | **Neither Dissatisfied or Satisfied** | **Satisfied** | **Very satisfied** |
|---|---|---|---|---|---|
| Overall, how satisfied are you with the quality of care for residents with SMI in the CLC? | 2.4 | 17.1 | 17.1 | 51.2 | 12.2 |
| In this CLC, how satisfied are you with the level of familiarity among staff with the special care needs of residents with SMI? | 12.5 | 27.5 | 22.5 | 30.0 | 7.5 |
| | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily** |
| In this CLC, how often do concerns come up regarding the care for residents with SMI? | 0.0 | 9.8 | 34.2 | 36.6 | 19.5 |
| | **Less than one third** | **Between one third and two thirds** | **Between two thirds and all** | **All** | **-** |
| To the best of your knowledge, what portion of the CLC staff has received training regarding care for residents with SMI? | 80.0 | 10.0 | 7.5 | 2.5 | - |
| | **Not at all important** | **Somewhat important** | **Very important** | **Extremely important** | |
| How important is it for CLC staff to receive additional training regarding care for residents with SMI? | 0.0 | 12.2 | 34.2 | 53.7 | - |
| | **Strongly Disagree** | **Disagree** | **Neutral** | **Agree** | **Strongly Agree** |
| CLC staff are fearful or uncomfortable interacting with residents with SMI | 2.4 | 24.4 | 34.2 | 29.3 | 9.8 |
| CLC staff voice displeasure about having to work with residents with SMI | 7.3 | 19.5 | 29.3 | 29.3 | 14.6 |
| Having to work with residents with SMI is contributing to staff burnout | 0.0 | 12.2 | 24.4 | 41.5 | 22.0 |
| CLC staff have the necessary knowledge and skills to care for residents with SMI | 17.1 | 48.8 | 19.5 | 14.6 | 0.0 |

*Notes*: SMI=serious mental illness, CLC=Community Living Center, the term for a U.S. Department of Veterans Affairs (VA) nursing home. CLC mental health providers on a VA national listserv were sampled, 41 out of 215 individuals on the listserv completed these items (response rate=19.1%).

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**Table 2.**

Responses Regarding Preferred Topics and Modalities for Training

| Training Topics | | | | % |
|---|---|---|---|---|
| Attitudes towards residents with SMI/addressing stigma | | | | 63.4 |
| Understanding symptoms of SMI | | | | 90.2 |
| Assessment and differential diagnosis of SMI | | | | 46.3 |
| Understanding the recovery model of care | | | | 65.9 |
| Communicating with residents with SMI | | | | 78.1 |
| Managing challenging behaviors | | | | 97.6 |
| When to seek a mental health consult | | | | 58.5 |
| How to identify additional resources/referrals in caring for residents with SMI | | | | 56.1 |
| **Training Modalities** | **Not at all effective** | **Somewhat effective** | **Very effective** | **Extremely effective** |
| Web-based training | 40.0 | 47.5 | 12.5 | 0.0 |
| Paper-based training (e.g., workbooks, manuals) | 43.9 | 46.3 | 9.8 | 0.0 |
| On-site training taught by a CLC staff member | 2.4 | 24.4 | 56.1 | 17.1 |
| On-site training taught by an outside consultant | 0.0 | 17.1 | 61.0 | 22.0 |
| Off-site training (e.g., at a conference or seminar) | 12.5 | 25.0 | 52.5 | 10.0 |
| Train-the-trainer (initial trainer receives off-site training) | 10.0 | 32.5 | 42.5 | 15.0 |

*Notes*: SMI=serious mental illness, CLC=Community Living Center, the term for a U.S. Department of Veterans Affairs (VA) nursing home. CLC mental health providers on a VA national listserv were sampled, 41 out of 215 individuals on the listserv completed these items (response rate=19.1%).

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**Table 3.**

Key Topics, Learning Objectives, and Resources for Nursing Home Staff Training Regarding Care of Residents with SMI

| Topic Area | Example Learning Objectives | Resources |
|---|---|---|
| Serious Mental Illness Diagnoses and Symptoms | **1** Name common SMI diagnoses and symptoms.<br>**2** Describe the course of SMI as episodic, with relapse and recurrence across the lifespan. | Substance Abuse and Mental Health Services Administration (SAMHSA)Issues-Conditions-Disorders Page<br>http://store.samhsa.gov/facet/Issues-Conditions-Disorders<br>Search here by diagnosis, symptom or topic for helpful, free, and printable handouts and information sheets.<br>National Institute of Mental Health (NIMH) Topics Page<br>http://www.nimh.nih.gov/health/topics/index.shtml<br>Good source for free and printable psychoeducational materials. |
| Recovery Model | **1** Define the concept of recovery from SMI.<br>**2** Describe strategies to promote recovery among residents with SMI. | SAMHSA – Working Definition of Recovery<br>https://store.samhsa.gov/system/files/pep12-recdef.pdf<br>Illness Management and Recovery Evidence-Based Practice KIT<br>http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463<br>Boston Center for Psychosocial Rehabilitation<br>https://cpr.bu.edu/resources |
| Stigma Busting | **1** Describe mental illness stigma and its negative impact on individuals with SMI.<br>**2** Express empathy towards individuals with SMI and their life experiences. | National Alliance on Mental Illness (NAMI)<br>http://www.nami.org<br>National Empowerment Center – Hearing Voices Curriculum<br>http://www.power2u.org/mm5/merchant.mvc?Screen=PROD&Store_Code=NEC&Product_Code=Curricula-HearingVoicesDistressing&Category_Code=hearingvoices<br>Mental Health America – The Importance of Person-Centered Language<br>http://www.mentalhealthamerica.net/person-centered-language |
| Connect and Communicate | **1** Demonstrate practical communication skills to build rapport with individuals with SMI.<br>**2** Name resources for family members of individuals with SMI. | Geriatric Mental Health Training Series<br>https://nursing.uiowa.edu/hartford/geriatric-mental-health-training-description<br>Depression and Adjustment in the Nursing Home – A Resource Toolkit<br>http://www.upmc.com/Services/AgingInstitute/resources-for-professionals/Documents/depression-adiustment-resource-toolkit.pdf<br>NAMI – Information for Family Members<br>https://www.nami.org/Find-Support/NAMI-Programs/NAMI-Family-to-Family |
| Cognition and Capacity | **1** Describe the differences in the progression of cognitive impairment in SMI versus dementia<br>**2** Describe the purpose and importance of a psychiatric advance directive. | American Psychological Association Assessment of Capacity in Older Adults<br>https://www.apa.org/pi/aging/programs/assessment<br>National Resource Center on Psychiatric Advance Directives<br>http://www.nrc-pad.org/ |
| Whole Health | **1** Name physical health symptoms and outcomes that should be monitored among adults with SMI | World Health Organization (WHO) Guidelines<br>Management of Physical Health Conditions in Adults with Severe Mental Disorders<br>https://www.who.int/mental_health/evidence/guidelines_physical_health_and_severe_mental_disorders/en/ |