Practice Concepts

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Psychologists in Long-Term Care (PLTC), a national network established in 1983, has developed, with input from colleagues and consumers, standards for psychological practice in long-term care facilities. These standards address provider characteristics, methods of referral, assessment practices, treatment, and ethical issues. This article describes the document's development and offers suggestions for its use.

Standards for Psychological Services in Long-Term Care Facilities

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In November 1995, members of the national network Psychologists in Long-Term Care (PLTC) began to discuss the idea of crafting standards for psychological services in long-term care facilities. For a number of years prior to the 1995 meeting, PLTC members were actively involved in delivering continuing education programs in clinical geropsychology. These programs were always well attended, particularly by experienced private practice clinicians who, due to changes in the health care market, were expanding their practices into the nursing home to care for older adults. These seasoned clinicians were typically bewildered by the many complex issues they were confronted with in geriatric care, including a variety of assessment, treatment and staff consultation concerns. PLTC members determined, therefore, that both clinicians and long-term care facility administrators needed standards that laid out the process of psychological service delivery in long-term care settings.

There were three distinct phases to the development of these standards. In phase one (November 1995 through August 1996), the PLTC workgroup completed an initial draft of the standards. Through the network's newsletter and the American Psychological Association (APA) Division 20 (Adult Development and Aging) E-mail network, comments were solicited from both the PLTC and Division 20 memberships through October 1996. In November 1996, a second draft of the standards was completed. Comments were again solicited from the aforementioned psychology groups, and, in addition, the second draft of the standards was sent out to several organizations with interest in this topic. These included the American Association of Homes and Services for the Aging, the State Medicare Directors workgroup, the Mental Health and Aging interest group of The Gerontological Society of America, the Nursing Home Reform Coalition, the American Association of Retired Persons Public Policy Institute, the Alzheimer's Association, and several divisions within the APA.

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Comments on the third draft were accepted through March 1997, when the final draft of the standards was completed.

Standards for Psychological Services in Long-Term Care Facilities

Introduction

Older adults are a diverse group. For many people, later life is a time of good physical health, personal growth, and heightened life satisfaction. Among community-dwelling older adults, the rates of depression and many other mental disorders are lower than for younger adults. The experience of older adults in long-term care facilities is quite different. Residents of long-term care facilities have very high rates of depression, dementia, and other mental disorders. Long-term care residents often have a combination of serious medical and psychological disorders, which reflect the interdependence of biological, psychological and social factors in aging.

The growth of interdisciplinary health teams in long-term care reflects the emphasis on a biopsychosocial model of clinical work with residents. In the long-term care population, comorbidity of multiple physical diseases and cognitive and affective disorders is common.

The psychologist's role on the interdisciplinary team is to detect and treat cognitive, affective and behavioral disturbance using psychological diagnostic and therapeutic tools. These tools may include cognitive, affective, behavioral, and personality assessments; individual, family, and group therapies; behavioral interventions; and staff education regarding the psychological needs of and clinical management strategies for residents in long-term care facilities.

Historically, psychological services for older adults were severely limited. In the first three decades of Medicare (until 1987), outpatient mental health services were capped at an annual rate of $250 per beneficiary. Reimbursement changes since then have encouraged a substantial increase in the number of psychologists practicing in long-term care settings. Toward the end of the 1980s, the cap was gradually raised, and it was removed altogether in July 1990. Some limiting factors in reimbursement continue because the required copayment remains at 50%, compared to the 20% copayment for medical services.

Mental health service opportunities in long-term care were greatly expanded with the passage of the Omnibus Reconciliation Act (OBRA 1989), which permitted licensed psychologists and social workers to serve as independent mental health providers under Medicare. In addition, OBRA 1987, 1989, and 1990 regulations included the Nursing Home Reform Act, which stressed the value of psychological services in the long-term care setting and the need to attempt psychosocial interventions before using chemical or physical restraints.

The expansion of geriatric mental health opportunities has greatly increased the demand for services at a time when the supply of well-trained practitioners is low. It will be a number of years before clinical training programs adequately incorporate the knowledge base and practice concepts of clinical geropsychology. During this transitional period, we urge practitioners to seek out continuing education opportunities in mental health and aging. In addition, we encourage experienced geropsychologists to share their expertise with new providers and consumers of mental health services for the aging. In this spirit, Psychologists in Long-Term Care proposes the following standards of practice. We hope that they will be used by practicing psychologists as general principles of assessment and treatment for residents of long-term care facilities and by other long-term care professionals as a guide toward understanding the role of psychologists.

Standards for Psychological Services in Long-Term Care Facilities

I. Providers

- A. Psychologists who are graduates of doctoral programs in psychology and are licensed in their respective states of practice.
- B. There are three categories of psychologists who practice in long-term care settings:
  1. Psychologists who are trained, experienced and competent in geropsychology service provision (see Appendix, Note 1).
  2. Psychologists who have formal training in geropsychology but are not yet experienced; these psychologists are supervised by experienced and competent geropsychologists (see category 1 above).
  3. Psychologists who are actively obtaining continuing education in geropsychology and are supervised by experienced and competent geropsychologists (see category 1 above).

II. Referral for Psychological Services

- A. Residents of long-term care facilities who are appropriate for psychological services exhibit behavioral, cognitive, or emotional disturbance. Examples of behaviors that may trigger referral include cognitive decline, excessive crying, withdrawal from social contact or other signs of depression, personality changes (e.g., excessively demanding behavior), aggressive or combative behavior, inappropriate sexual behavior, or psychotic behavior. Psychologists encourage the referral source to be as specific as possible about the presenting problem. Standing or "prn" orders for psychological services are discouraged.
- B. In addition to direct assessment and treatment of patients referred for psychological

services, psychologists may also provide staff consultation and advisement, staff training and education, family consultation and advisement, design and implementation of preventive screening and other institutional programs, environmental assessment, behavioral analysis and design of behavior management programs, and other services. Psychologists are aware that many of these latter services may not be third-party reimbursable.

III. Assessment

A. In order to provide cost-effective and high quality treatment, psychologists assess the cognitive, emotional, and behavioral functioning of their patients. Assessment procedures may include the following components:

1. Assessment of mental status through clinical interviews, mental status questionnaires, and information obtained from family, staff, or other informants.
2. Psychological testing, including assessments of personality, emotional functioning, and psychopathology, using measures or instruments consistent with current standard professional practice (see Appendix, Note 2).
3. Neurobehavioral testing, which serves to determine cognitive strengths and weaknesses, memory capacities, and specific neuropsychological impairments. Such testing may include assessments of attentional, language, memory, visuospatial, and abstract reasoning skills. Testing time may be brief. Reasons for neurobehavioral testing may include: (a) resolving diagnostic ambiguities (e.g., whether dementia or depression or both are present), (b) assessing sudden cognitive declines or changes (e.g., whether delirium is present), (c) profiling cognitive strengths and weaknesses (e.g., for treatment planning), (d) determining the level of care needed for a patient, (e) planning a program of rehabilitation, and (f) determining competency.
4. Functional assessments, which address a range of behaviors relevant to overall daily functioning, including self-care skills and everyday living skills. Functional assessments often augment personality, mental status and neurobehavioral assessments.
5. Behavioral observation and analysis, which includes the systematic observation and recording of behavior and stimulus-response and response-reinforcement contingencies, in order to design behavioral interventions that will increase the frequency of positive behaviors and decrease the frequency of negative behaviors.

B. Psychologists are aware of their responsibilities, as integral members of interdisciplinary teams, to work with their medical and pharmaceutical colleagues to develop and implement integrated plans of service delivery. Psychologists encourage appropriate medical and physical examinations, including laboratory tests and radiological studies, to rule out reversible causes of functional impairment, such as medically treatable illnesses.

IV. Treatment

A. Treatment plan

1. Each patient has an individualized treatment plan that is based on the specific findings of a psychological assessment and that addresses the referral question.
2. The treatment plan includes a diagnosis and specific therapeutic modalities to achieve short-term and long-term goals.
3. When treatment frequency deviates from standard practice it is justified in the treatment plan.
4. Changes in clinical status are reflected by changes in the treatment plan.

B. Treatment process

1. Treatments are chosen that best address each patient's diagnosis and presenting symptoms.
2. Treatment modalities may include, separately or in conjunction, individual psychotherapy, behavior therapy and behavior modification, group psychotherapy, and family psychotherapy.
3. Treatments are empirically informed and reflect current standards of geropsychological practice.
4. Psychologists are aware that most third-party reimbursement requires the full duration of treatment sessions to be spent in face-to-face contact with the patient and/or the patient's family, and that other important and necessary treatment-related time, such as consultation with staff, may not be third-party reimbursable.
5. Psychologists are aware of their responsibility to spend adequate time in face-to-face treatment with each patient and to consult and coordinate with the interdisciplinary team. Psychologists do not attempt to treat an excessive or inordinate number of patients in a single day.
6. Treatment continues when emotional, cognitive, or behavioral progress toward a goal can be demonstrated. When no such progress can be demonstrated, but the patient appears to benefit from a social visit, appropriate recommendations for friendly visitors, activities, etc., are made.

7. When treatment is ended, termination is conducted in an orderly manner; the patient is prepared and given appropriate notice, and issues involving termination are addressed.

C. Outcomes

1. Patient progress toward stated goals is regularly monitored and documented to determine if treatment is effective and whether it should be continued, modified or terminated. Such monitoring is done at least every 3 months.
2. Treatment outcome can be measured in multiple domains, including affective, cognitive or behavioral domains.
3. Positive treatment outcome can include stabilization of mental and behavioral disorder where decline would be expected in the absence of treatment. However, when treatment for such a patient is long-term, attempts are made to decrease the frequency of service. If the patient responds with a worsening of symptoms then treatment can be reinitiated.

D. Documentation

1. Psychologists provide timely and clear documentation of each patient's diagnosis, treatment plan, progress and outcome in accordance with current ethical and legal standards.

V. Ethical Issues (see Appendix, Note 3)

A. Informed consent

1. Informed consent decisions are based on the legal competency of the patient to make informed decisions regarding health care, the patient's knowledge of the long-term care setting, the cognitive ability of the patient, the availability of family members, and the acuity of the psychological condition requiring treatment.
   a. For a competent person without significant cognitive impairment, before any psychological services are rendered, the psychologist provides to the patient a clear statement of the condition warranting psychological services, what services are to be rendered, and the possible consequences of accepting or refusing services.
   b. For a patient declared legally incompetent, the psychologist provides to the guardian a clear statement of the condition warranting psychological services, what services are to be rendered, and the possible consequences of accepting or refusing services. Although informed consent must be given by the guardian, the psychologist also attempts to help the patient understand the rationale for treatment (within the limits of the patient's cognitive abilities).
   c. For a patient with significant cognitive impairment who is deemed to be without the capacity to understand the rationale for treatment but who has not been declared legally incompetent, the psychologist identifies the responsible party and provides the rationale for treatment to that party. Although, technically, the patient still legally retains the right of decision making, ethically, the clinician must contact caregivers to help with decision making. The psychologist also attempts to help the patient understand the rationale for treatment.
   d. Consent for services is not required if the patient is considered dangerous to self or others (as defined by applicable state law).
2. Psychologists who are part of a staff institutional team, privileged by the institution to provide services, and covered by a general institutional consent do not need to get separate informed consent before implementing treatment. Consulting psychologists who are not part of the staff institutional treatment team must get separate informed consent as described in Section A, Part 1, before services are provided.

B. Confidentiality

1. Patients in long-term care facilities have the same rights to confidentiality regarding psychological services as all other patients, and information about this right to confidentiality as well as its limits, is offered to patients, guardians, or responsible parties as part of the informed consent process prior to service delivery.
2. Psychologists are aware of limits to confidentiality and make every effort to reconcile these limits with the rights of their patients.
   a. Although competent patients, guardians, or responsible parties have rights concerning what information is given to the staff in a long-term care facility, these rights do not extend to information that is deemed critical to protecting the resident from harming self or others.
   b. Confidentiality standards must be consistent with the reporting/charting regulations within which the facility must operate. If a conflict arises, the psychologist strives to work with the facility to achieve maximum consistency.

c. Confidentiality standards should allow for the demands of the psychologist's role as an active member of an institutional treatment team that shares pertinent information with other health professionals.

C. Privacy
   1. Psychologists try to ensure that psychological services are provided in the most private manner possible.
   2. Psychologists often need to be creative in meeting the privacy standard. Some long-term care facilities provide private consulting rooms for psychologists but many do not. When no consulting room is available or the patient is bedridden, services may be provided at the patient's bedside. If the patient is in a nonprivate room, the psychologist may request that the roommate leave until the session is over and then close the door. If the roommate is also bedridden or refuses to leave the room, the session may be conducted (with the roommate's consent) by drawing the curtain around the bed to provide some privacy. Nursing staff are notified so that they know where the patient can be found and so that they do not interrupt the session.
   3. Psychologists are aware of facility/state/federal regulations regarding treatment privacy.
   4. Patients are consulted regarding their comfort with privacy arrangements prior to a treatment session, and every effort is made to accommodate their wishes.

D. Conflict of interest
   1. Psychologists self-refer only if a need for psychological services is identified and members of the interdisciplinary treatment team are made aware of the need for services.
   2. Psychologists are aware that at times the interests of the facility and the patient may not coincide and make every effort to resolve the conflict in the best interests of the patient.
   3. Psychologists try to ensure that patients receive proper continuity of care. If psychological services are interrupted due to payment issues, institutional barriers, or other nonclinical reasons, the psychologist follows accepted professional standards regarding proper therapeutic closure and transfer of care via referral.
   4. Psychologists are aware of the rules and regulations governing third-party reimbursement and follow them when billing for reimbursable services, but patient care decisions are guided by the best interests of the patient and are not dominated by reimbursement considerations. When psychologists believe that reimbursement regulations require revision, they attempt to secure appropriate changes from state/federal agencies and private insurers.

E. Advocacy
   1. Psychologists advocate for the appropriate use of mental health services to reduce excess disability and improve quality of life.
   2. When mental health services are not being used or are being used inappropriately, psychologists strive to educate other care providers to improve the delivery of care in order to be consistent with a biopsychosocial approach to the assessment and treatment of older adults.

Conclusions

PLTC's membership and the authors of these standards are widely known for their decades of work in long-term care. All of the authors were involved in delivering psychological practice in long-term care settings well before Medicare payments became available to psychologists in 1990. Peter Lichtenberg, the first author credited on these standards and this article, was the first person to write a book for psychologists on how to practice in geriatric long-term care [*A guide to psychological practice in geriatric long-term care*. (1994). Binghampton, NY: Haworth Press]. These authors thus not only possess the experience and familiarity with long-term care necessary to develop these standards, but also will use these qualities to disseminate these standards and to educate others in their proper usage.

During the summer of 1997, PLTC created a task force headed by Erlene Rosowsky to develop a strategic plan for the dissemination of these standards. It is anticipated that the standards will be aimed at three major audiences: psychologists, long-term care facility administrators, and insurers and regulatory personnel [i.e., Medicare carriers, state Medicare Medical Directors, representatives of the Health Care Financing Administration (HCFA)]. It is crucial that psychologists practicing in long-term care settings become aware of these standards, and that they attempt to conform to the practices described therein. Long-term care facility administrators are becoming more familiar with the services that psychologists can provide, and will benefit from using these standards to help ensure quality service provision. Finally, administrators of insurers and regulatory agencies need to become aware of the progress that psychologists themselves have made in defining their own practice. It is hoped that these standards will help insurance claim reviewers and regulatory boards make logical and balanced decisions about what is and what is not acceptable geropsychological practice.

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Appendix

Notes

1. For further discussion of these issues, see the Draft Report of the APA Interdivisional Task Force on Qualifications for Practice in Clinical and Applied Geropsychology, 1996, Section II (Clinical Geropsychology) of Division 12 (Clinical Psychology) and Division 20 (Adult Development and Aging), which may be obtained through the corresponding author. Category 1 includes psychologists who have either a generalist or a specialist level of training in clinical geropsychology, as these levels are defined in the Draft Report.
2. See, for example, U.S. Department of Veterans Affairs *Geropsychology Assessment Resource Guide*, 1996 Revision. This guide may be obtained for a fee through National Technical Information Service, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161. Request publication #PB96-144365.
3. In addition to the standards presented here, psychologists follow the APA Ethics Code [American Psychological Association. (1992). *Ethical principles of psychologists and code of conduct*. Washington, DC: Author; also published in *American Psychologist, 47*, 1597–1611].