

PLTC Guidelines for Psychological and Behavioral Health Services in Long-Term Care Settings

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In 1995, Psychologists in Long-Term Care (PLTC) began discussions regarding developing initial standards for the practice of psychology in long-term care (LTC). The focus was on geropsychology, primarily conducted in skilled nursing facilities. The history leading to this project was the apparent lack of training among many clinicians who were expanding their practices into LTC where even "...seasoned clinicians were typically bewildered by the many complicated issues they were confronted within geriatric care, including a variety of assessment, treatment, and staff consultation concerns" (Lichtenberg et al., 1998, p.122). PLTC members determined, therefore, that both clinicians and LTC facility administrators needed basic standards to guide the appropriate delivery of psychological services in LTC settings.

When the first PLTC standards were published (Lichtenberg et al., 1998), provider psychologists were defined as "psychologists who are trained, experienced and competent in geropsychology service provision, psychologists who have formal training in geropsychology but are not yet experienced who are supervised by experienced and competent geropsychologists, or psychologists who are actively obtaining continuing education in geropsychology and are supervised by experienced and competent geropsychologists (p.123)." Additionally, there was a listing of other core domains with relevant standards.

Now 20 years later, many aspects of LTC psychology reflect shifts in the demographics of LTC residents. As indicated below, there is increasing research documenting the effectiveness of LTC interventions to address the myriad psychological conditions of LTC residents, a growing number of whom are younger and diagnosed with Serious Mental Illness (SMI) and a broad range of neuropsychiatric conditions (e.g. , seizure disorders, Parkinson's disease, traumatic brain injury (TBI)), and an increasing proportion of short-term residents who are receiving intensive rehabilitation therapies with the goal of returning to their private residences. Thus, compared to the past, many patient variables have changed in LTC settings including age, medical conditions, psychological and behavioral conditions, length of stay, and goals of the LTC placement. Consequently, PLTC formed a Task Force to revise the 1998 standards to reflect current LTC psychological practice, and to move away from prescriptive 'standards' terminology to aspirational guidelines. Given the diversity of LTC residents and settings, as well as the American Psychological Association's (APA) shift away from promulgating standards, the current authors viewed the formulation of guidelines as the most appropriate way to assist psychologists who either currently practice, or who are considering providing services in LTC settings.

Long-term care may be defined as the care provided to those individuals with severe or multiple medical problems that interfere with daily living and who require prolonged healthcare, often delivered in an institutional setting. It is a rapidly evolving and growing field for psychologists, especially given the prevalence of psychiatric disorders for residents in institutional LTC (Seitz, Purandare, & Conn, 2010), the challenges posed for their caregivers (Gaugler, Roth, Haley, & Mittelman, 2008), and the changing demographics. In one systematic review of the prevalence of psychiatric disorders in LTC ‘homes,’ the authors (Seitz, Purandare, & Conn, 2010) found a 10% median prevalence of major depressive disorder, 29% with depressive symptoms, 58% with dementia, 78% of those with dementia having behavior symptoms, and widely varying rates of anxiety disorder with one study reporting close to a 12% prevalence.

There has been a growing evidence base on the effectiveness of psychological interventions for older adults in general and in LTC specifically. Research has consistently indicated that psychotherapy is effective in the treatment of older adults (Gatz et al., 1998; Scogin & Shaw, 2012). Cognitive Behavior Therapy is effective for a wide variety of psychological problems in older adults especially depression, anxiety, and substance abuse (Gallagher-Thompson, Steffen, & Thompson, 2008). For the LTC population, behavioral activities intervention (BE-ACTIV) (Meeks, Looney, Van Haitsma, & Teri, 2008) and structured reminiscence interventions reduce depression in nursing home (NH) residents (Haight, Michel, & Hendrix, 2000; Chiang et al., (2009)), even for those with cognitive impairment (Woods, Spector, Jones, Orrell, & Davies, 2005). The Montessori tailored approach engages even residents with severe dementia (van der Ploeg, Eppingstall, Camp, & Runci, 2008), and the Staff Training in Assisted Living Residences – Veterans Affairs (STAR-VA) program uses a multi-component interdisciplinary behavioral approach to reduce challenging behaviors of NH residents diagnosed with dementia (Karlin, Visnic, McGee, & Teri, 2014). Promising individualized intervention programs are also available for managing challenging behaviors of residents with dementia (Cavanagh & Edelstein, 2017). The expanding roles for psychology and opportunities for innovative mental health care delivery in LTC settings based on evolving best practices have recently been described (Carney & Norris, 2017), and are advancing internationally (Molinari & Ellis, 2017)

In addition to the need to address the “Silver Tsunami” of aging persons (Bartels & Naslund, 2013), many of whom are the oldest-old who will require both geropsychological and LTC services, changes in the healthcare marketplace have resulted in younger persons (i.e., those under age 65 representing roughly 12 to 14% of NH residents) becoming the fastest growing segment of the institutional LTC population (CDC, 2008; Shapiro, 2010). The recognition of the need for LTC residential services for some of those with developmental disabilities (DD) or TBIs has further broadened the purview and definition of LTC. Singh (2010) noted that over 40% of those who need LTC are less than 65 years of age, including children and adolescents with intellectual disability and DD, young adults with congenital degenerative conditions or acquired brain injury, and people with HIV/AIDS. Residents with SMI, many of whom are younger than ‘typical’ NH residents, pose an additional challenge with regard to behavior management

Although one review suggested that there may be declining rates of individuals with a diagnosis of schizophrenia (from 9% to 6%; Seitz, Purandare, & Coon, 2010), other studies indicate that those with SMI make up perhaps 10% of the NH population in at least some states (Becker & Mehra, 2005; McCarthy, Blow, & Kales, 2004). Indeed some studies suggest that between 25% - and 50% of residents in assisted living facilities carry a psychiatric diagnosis, with 12% diagnosed with a psychotic disorder (Becker, Stiles, & Schonfeld, 2004; Rosenblatt et al., 2004). Using a narrow definition of SMI (i.e., bipolar disorder and schizophrenia), recent data collected by the Centers for Medicare and Medicaid Services (CMS) suggested that the prevalence of SMI in nursing homes is approximately 20% (PASRR Technical Assistance Center, 2017).

Finally, in California there is a growing sub-set of individuals referred from the criminal justice system, given a general effort to shift costly medical services from correctional budgets to Medicaid and Medicare by moving medically impaired inmates from the correctional system into NHs (Gibson & Ferrini, 2014). Although these authors specifically described this trend as it relates to California, anecdotal evidence in other states suggests that it is not unique to California.

The fact that most residents of nursing homes are older adults has led some psychologists to assume that psychologists working in LTC require a skill set that is merely a sub-set of geropsychology competencies. While there certainly exists strong overlap between LTC psychology and geropsychology, there is also significant divergence between the two, with LTC psychology being a distinct practice area. Understanding of developmental, cognitive, and personality changes across the lifespan, of not only older adults but also those younger patients with DD and TBI, complement basic knowledge of geriatric LTC. Complications from co-morbid medical problems are inherent across the age spectrum of LTC residents, and professional engagement in LTC now requires addressing acute and chronic medical problems, rehabilitation needs, and end-of-life issues across the life span.

In spite of these shifts in demographics and clinical characteristics of LTC residents, the Pikes Peak Model for Training in Professional Geropsychology remains foundational as a framework for training and the development of competency in geropsychology, and implicit in much of this model is guidance regarding those competencies needed for adequate delivery of LTC services. When discussing complexity of providing psychological services to geropsychology populations, the authors of the Pikes Peak model (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009) stated:

“As issues become more complex and more specialized in their nature (e.g., potential presence of dementia, complications from comorbid medical problems, assessment of decision-making capacity, nursing home consultation), the need for geropsychology competence increases (p. 206).”

In the provision of psychological services to the diverse range of LTC residents, including many who are not geriatric, these and many of the other Pikes Peak competencies are applicable.

Persons who have a wide range of neurocognitive disorders are frequently encountered, even with younger residents in LTC settings. In light of the heterogeneity of LTC residents, it is suggested that psychologists be knowledgeable of the full range of psychopathology, its prevalence across the lifespan, and appropriate assessment methodologies and evidence-based treatments.

Psychologists provide valuable services in LTC settings, but there remains a need for more LTC psychologists and for training in the area. With only 4.2% of psychologists focusing on geriatrics in clinical practice (APA, Center for Workforce Studies, 2008), it might reasonably be assumed that even fewer are receiving training specific to LTC. According to a survey of psychologists who are Health Service Providers, over 60% of licensed psychologists at least occasionally provide care to adults over the age 65. However, perhaps only 1% identify geropsychology as their main specialty (APA, 2016.) The large percentage of psychologists who occasionally provide services in LTC settings but do not identify as geropsychologists may benefit from guidance regarding important practice matters in LTC psychology. Additionally, there seems to be a need among LTC psychology trainees for professional guidance regarding professional competence to practice in LTC settings. Indeed, few graduate training programs in geropsychology have a focus on LTC. As with the Pikes Peak Model, our goal with these guidelines is to provide an aspirational model for the practice of psychology in LTC settings.

Methodology for the Revision

Because advances in the provision of psychological and behavioral health services in LTC in the past two decades, the PLTC membership identified a need to update the 1998 *Standards for Psychological Services in Long-Term Care Settings*. A post was placed on the PLTC LISTSERV to solicit membership in a group of those interested in revising the Standards of Psychological Services in Long-Term Care Settings, which was published in 1998. Members of this PLTC Guidelines Revision Task Force discussed the content that needed to be changed and decided on a new overall framework to guide the revised standards. Given the focus on providing an aspirational framework and guidance, a shift in terminology was made from “standards” that are more prescriptive to that of proposed “guidelines.” The revised title also reflects that PLTC addresses both psychological and broad behavioral health services in LTC.

Now termed the PLTC Guidelines Revision Task Force, the members discussed the content that needed to be changed and decided on a new overall framework to guide the revision. A rationale was advanced regarding why a revision was needed and how psychological practice in LTC had changed over the years. The original emphasis on institutional LTC was retained. Professionals with expertise in the different domains of the new guidelines were then identified and asked to take the lead in reviewing and making revisions for the particular content areas that they were assigned. The original document with an updated Introduction was then revised in accordance with changes made by the PLTC guidelines revision task force and the consulting experts. This draft was then reviewed and modified according to written remarks and edits made by the PLTC

Executive Board, and oral comments by the general membership during a PLTC Conversation Hour conference call. This second revised draft was then circulated to the PLTC Executive Board before the guidelines were formally approved, endorsed and vetted into its current form. Regarding terminology, the decision was made to be inclusionary and to use ‘client’, ‘patient’, and ‘resident’ interchangeably in this document as befit the particular context of the Guideline addressed.

I - Providers

A. Training

Psychologists who practice in long-term care (LTC) settings are licensed in their respective state(s) and are encouraged to follow the standards for professional competence articulated in the APA (2017a) *Ethical Principles of Psychologists and Code of Conduct*.

As LTC settings and residents are becoming increasingly diverse, providers are encouraged to ensure that they possess education, training or supervised experience relevant to the populations served and setting in which they practice.

Psychologists are encouraged to engage in outside expert consultation, or otherwise obtain established scientific and professional knowledge to meet the needs of the residents they serve as needed.

The Pikes Peak Model of Training and the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel et al., 2012) are useful for identifying some of the core knowledge and skill competencies needed to provide services to older adults in LTC and to determine whether additional education and training is necessary.

. Depending upon the LTC setting, education and training in geropsychology provides a solid foundation which can be complemented by education and training in relevant aspects of other psychological specialties, such as health psychology, rehabilitation psychology, neuropsychology, and forensic psychology, for the optimal delivery of services.

B. Knowledge/Skills of LTC

B1. Understanding Systems of Care

Psychologists strive to understand the LTC system. In particular, psychologists try to recognize how to work effectively within LTC organizational/institutional structures, and how to foster

appropriate transfers and transitions from one LTC setting to other facilities and residences. Psychologists are encouraged to have an understanding of skilled nursing facilities, dementia care units, Institutes of Mental Diseases, hospice, relevant state and federal regulations (e.g., Title 42 of the Code of Federal Regulations), Pre-admission Screening and Resident Review (PASRR), and the Olmstead Act.

Additionally, psychologists endeavor to be familiar with the funding and reimbursement aspects of clinical services provided in LTC such as Medicaid, Medicare, Social Security, Supplemental Security Income, use of a payee, etc. Psychologists are also encouraged to understand their role in integrated care and strive to be active members of interdisciplinary teams and to manage possible conflicts arising from their work within an organization (e.g., balancing organizational interests with resident quality of life/ mental health needs).

Psychologists are encouraged to understand nursing culture and operations, including becoming familiar with medical terminology, the Minimum Data Set, the PASRR, care planning, and the professional responsibilities of the Medical Director, Director of Nursing, registered nurses, licensed practical/vocational nurse, and certified nursing assistants. Understanding the roles of other treatment team members, such as rehabilitation therapists and dieticians, also promotes patient care.

Psychologists are encouraged to support and educate staff in person-centered care. The Centers for Medicare and Medicaid Services criteria are helpful in determining the extent to which resident needs are being met by the facility (<http://cmscompliancegroup.com/wp-content/uploads/2017/08/CMS-20067-Behavioral-Emotional.pdf>).

B2. General Clinical Issues

Psychologists in LTC are encouraged to employ evidence-based treatments adapted to suit the particular needs and concerns of LTC residents.

Psychologists are encouraged to articulate the unique ways that the common psychological problems of depression and anxiety are manifested and triggered by the stressful transitions into the LTC setting and adjustment to living in a communal setting; how SMI and personality disorders may be exacerbated by these changes; and how medical and cognitive co-morbidities interact with these conditions to present a complex clinical picture.

Psychologists strive to learn how a wide range of problems and issues (e.g., substance abuse, pain, chronic illness, end of life care, sleep disorders) contribute to the presenting mental health problems of LTC residents.

Psychologists strive to learn the most common side-effects of frequently used medications, and how these side effects may relate to the cognitive functioning, behavioral, and psychological manifestations of the residents' presenting problems.

Psychologists are encouraged to understand those factors that promote quality of life for most residents, such as involvement in meaningful activities, social engagement, person-centered care, and exercise of autonomy (e.g., whenever possible allowing individuals in LTC to make their own decisions about when they sleep or eat).

B3. Death and Dying

Although not a comprehensive list, themes in therapy that often arise at the end-of-life (EOL) include (anticipatory) grief, existential distress, processing losses (interpersonal, functional, identity, etc.), and legacy building. Additionally, therapy may address psychological and/or psychiatric conditions with onset predating or precipitating one's medical illness (Kasl-Godley & Hiroto, 2018). Often, previously mentioned problems and/or psychological distress can be exacerbated by the experience of living with advanced illness and/or debility. Further, psychological distress can exacerbate one's experience of "total pain" (physical, psychological, spiritual, or existential pain), and often requires an interdisciplinary approach to pain management including non-pharmacological approaches (Mehta & Chan, 2008).

During EOL treatment, psychologists are encouraged to provide support to patients living with life-limiting illness and to their family members and friends as needed (Haley, Kasl-Godley, Larson, & Neimeyer, 2003; Kasl-Godley, King, & Quill, 2014; Qualls & Kasl-Godley, 2011). This support may take the form of individual, couple, or family psychotherapy and can occur before and after diagnosis, during advanced illness, and after death for family members.

Psychologists in LTC working with people with life-limiting or terminal illness strive to be knowledgeable about how to modify evidence-based therapies (e.g., Acceptance and Commitment Therapy, CBT) as needed to address the unique needs of those at EOL, in part (and if applicable) to align with the philosophy of palliative and hospice care.

Psychologists are encouraged to mediate on behalf of their patient and at the patient's request when family conflict occurs regarding EOL decisions.

Psychologists strive to make recommendations to LTC staff to tailor care and minimize compassion fatigue and moral distress, especially in contexts of family conflict and/or psychiatric disorders.

Psychologists strive to understand and integrate into their therapy aspects of patients' cultural identity and familial concerns related to death and dying. Cultural considerations may include beliefs about aging, illness (e.g., etiology, treatment), the dying process, and cultural traditions/ceremonies/beliefs after death.

Psychologists strive to educate LTC patients and their families regarding advance care planning, code status, and surrogate decision-making (Clayton, Hancock, Butow, Tattersall, & Currow,

2007). Such tasks may also be completed by other team members, including social work, if available.

Psychologists strive to educate dying patients and their families about EOL options. These might include, for example, interventions and their risks and benefits; comfort versus disease-directed treatment; non-beneficial/futile/non-indicated care; completion of Physician's Orders for Life-sustaining Treatment (POLST) forms, palliative care; and hospice versus additional interventions.

Psychologists should be aware of the legal, ethical, religious, and clinical issues regarding voluntary refusal of life-sustaining measures by a cognitively intact person or via proxy (advance directive/agent/surrogate) (Pope & West, 2014; Quill & Byock, 2000). Psychologists strive to understand these issues as they relate to Physician Aid-in-Dying (in some states). For further guidance, see the latest APA Resolution on this topic (APA, 2017).

II - Referral for Psychological Services

Residents of LTC facilities who exhibit behavioral problems, cognitive deficits, or emotional distress may be referred for psychological or behavioral health services by various parties, such as facility social workers, nurses, physicians, other professionals, family members, and occasionally residents themselves. Although many facilities require a physician's order for mental health services, other means of referral and even self-referral due to resident request, observations by psychologists or observations by other staff may be appropriate.

Examples of common reasons for the need for psychological services include changes in cognitive functioning, non-adherence with medical treatments, behavior or personality changes, unmanaged pain, signs of depression (e.g., crying, withdrawal, sadness, self-destructive behaviors, or suicidal statements), signs of anxiety (e.g., fearfulness, restlessness, expressions of worry), aggressive, combative, or agitated behavior, inappropriate sexual behavior, psychotic behavior and the need for non-pharmacological treatment, or relationship problems with family, staff, or other patients.

If the LTC setting allows for self-referral by psychologists, psychologists endeavor to document clearly the need for psychological services, and to communicate the rationale and referral to the interdisciplinary team.

Psychologists are encouraged to determine the appropriateness of the referral for services and typically discuss the reasons for mental health services with the referring party. Routine orders for psychological treatment are discouraged. In some states if a patient is in treatment with a psychologist it may be appropriate for the physician order to be included in the standing orders during the time the patient is in treatment

Prior to initiating services, psychologists are encouraged to establish who is responsible for payment of services, and to be aware of reimbursement rules and restrictions of third-party payers, such as Medicare (see MLN Matters, 2018: Medicare Payments for Part B Mental Health Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0816.pdf>).

In addition to direct clinical services, psychologists are encouraged to provide various indirect services, such as staff consultation, training, and education; participation in interdisciplinary team conferences, family consultation and support; and promotion of the design and implementation of preventive services and institutional programs, such as educating staff about non-pharmacological treatment alternatives (CMS, 2015, April 14), patient-centered care, environmental assessment, behavioral analysis, and design of behavior management programs (particularly for residents who are too cognitively impaired to benefit from direct psychological services).

Psychologists are encouraged to be aware that indirect services, such as those described above are typically not reimbursed by insurance entities. Every effort is made to offer services when possible.

III - Assessment

To provide cost-effective and high-quality treatment, psychologists assess the psychological and adaptive functioning of their patients.

Psychologists are encouraged to use multiple assessment methods when possible, including reviewing records clinical interviewing, direct behavioral observation, self-report, informant report, assessment instruments as indicated, electronic activity and sleep monitoring, and psychophysiological techniques.

Psychologists strive to select and use psychological assessment instruments that are consistent with current professional practice and the Standards for Educational and Psychological Testing established by the American Educational Research Association, the APA and the National Council on Measurement in Education (American Psychological Association, 2014).

With regard to cognitive assessment, psychologists are encouraged to determine cognitive strengths and weaknesses, and specific cognitive deficits when conducting cognitive assessments. Such testing may include assessments of attention, language, memory, visuospatial skills, abstract reasoning, and other executive functions. Psychologists are encouraged to consider and to assess objectively symptom and performance validity when the patient's level of functioning permits. Reasons for cognitive assessment may include (a) diagnostic clarification (e.g., whether dementia or depression or both are present); (b) assessment of sudden cognitive declines or changes (e.g., whether delirium is present); (c) profiling cognitive strengths and weaknesses (e.g., for treatment planning, staff, or family guidance); (d) determination of the

level of care needed for the patient and whether the current place of residence is appropriate to meet the patient's needs; (e) planning a program of rehabilitation; (g) assistance with the determination of capacity (e.g., capacity to consent to treatment; capacity to live independently); and (f) improvement of quality of life. Referrals to, or consultation with, neuropsychology occurs as needed.

Psychologists are encouraged to address a wide range of adaptive behaviors relevant to overall daily functioning, conducting functional assessments of self-care skills and everyday living skills. Functional assessments often augment other psychological assessment. More specific functional skills assessment (e.g., decision-making) is an important element of capacity assessment.

Psychologists are encouraged to assess social relationships. The individual's appraisal of the social interactions mediates the relation between the interactions and psychological health. Therefore, it is important to assess both positive and negative appraisals of social interactions between individuals and within their social networks. Psychologists are encouraged to assess for the experience of social isolation as loneliness is associated with diminished mental and physical health across the lifespan (Beutel et al., 2017).

When deemed appropriate, psychologists are encouraged to conduct functional analyses and assessments. These may be particularly helpful in the assessment of maladaptive behaviors. This analysis and assessment includes the systematic observation and recording of behavior, and the identification of its antecedents and consequences to establish causal relations regarding behavior deemed inappropriate. This information can be utilized in the development of interventions that increase the frequency, duration, or intensity of adaptive behaviors and decrease the frequency, duration, or intensity of maladaptive behaviors. As integral members of interdisciplinary teams, psychologists endeavor to work with colleagues to develop and implement integrated plans of service delivery.

Psychologists are encouraged to consider potential psychological manifestations of physical diseases. Examples of such manifestations include anxiety associated with chronic obstructive pulmonary disease, and depression as a reaction to a diagnosis of dementia. Similarly, psychologists strive to consider physical manifestations of psychological distress (e.g., somatic symptom disorders) in situations in which medical explanations for physical symptoms are lacking.

Psychologists are encouraged to understand the possible side effects of medications used to treat physical diseases and mental disorders (e.g., drowsiness caused by anti-seizure medications). Patients may benefit from psychoeducation regarding the adverse effects of some medications which can result in iatrogenic conditions.

Psychologists are encouraged to obtain repeated assessments to aid in the establishment and evaluation of intervention programs, and to guide the treatment process. If possible, a final outcome assessment may be made to determine treatment effectiveness.

Psychologists strive to be aware of diversity among adults in LTC and how issues of age, sex, gender identity, race, ethnicity, religion, socioeconomic status, sexual orientation, the impact of psychological trauma, and disability can affect the clinical presentation and the assessment process and outcome. Psychologists may also evaluate how these diversity factors impact residents' relationships with staff and other residents, and whether biases may be impacting residents' care and quality of life.

Psychologists are encouraged to understand the need for appropriate medical and physical examinations, including laboratory tests and radiological studies, and to make referrals to other health care disciplines (e.g., OT, PT), to assist with diagnostic clarification and treatment as needed, to rule out reversible causes of functional impairment, such as medically treatable illness.

IV - Treatment

A. Treatment Plan

Psychologists are encouraged to develop an individualized treatment plan as necessary for each resident that is based on the specific findings of an appropriate psychological assessment and addresses the goals, preferences, and unique needs of the resident.

The treatment plan includes a mental health diagnosis or clearly defined problematic behavior(s) and defines the therapeutic goals in relation to that diagnosis or problem behavior(s) and the personal goals, preferences, and unique needs of the older adult.

When treatment is delivered in a specific setting that may have implications for the process, experience, or outcomes of therapy (e.g., home, physician's office, or LTC setting), psychologists are encouraged to include goals addressing those implications and/or coordinating care within that setting in the treatment plan.

Psychologists are encouraged to specify the therapeutic modalities that will be used to achieve the short-term and long-term therapeutic goals of the treatment plan.

Psychologists are encouraged to note in the treatment plan any treatment modalities that are adapted to meet the unique needs including disability or other diversity needs, of the individual.

In constructing the treatment plan, psychologists are encouraged to outline the frequency and expected duration of therapy required to achieve the therapeutic goals.

When treatment frequency or duration deviates from the initial treatment plan, psychologists are encouraged to provide an update to the treatment plan that supports the need for additional services.

Psychologists are encouraged to review the treatment plan and update it in collaboration with the resident at regular intervals to ensure that goals are being met, modalities are effective, and treatment is proceeding as anticipated.

B. Treatment Process

Psychologists are encouraged to choose evidence-based interventions that best address each patient's diagnosis and/or presenting symptoms, and reflect current standards of relevant psychological practice.

Treatment approaches may include, separately or in conjunction, individual psychotherapy, behavior therapy, cognitive-behavioral therapy, group psychotherapy, family psychotherapy, or other appropriate therapies or interventions. Additional services that promote the patient's well-being but are not provided directly to the patient (e.g., environmental management) can also be valuable.

Psychologists strive to spend adequate time in face-to-face treatment with each patient and to consult and coordinate with the interdisciplinary team and family members, and surrogate decision-makers where appropriate.

Psychologists are encouraged to understand that treatment continues when measurable emotional, cognitive, or behavioral progress toward a goal can be demonstrated or treatment serves to maintain behavioral or functional equilibrium. When no benefit can be demonstrated, alternate approaches for achieving the goal are attempted, or the goals are modified accordingly.

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. Evaluation

Psychologists strive to regularly monitor and document patient progress toward stated goals to determine if treatment is effective and whether it should be continued, modified or terminated. Such monitoring typically may be done at least every 3 months, but often much more frequently, particularly for patients with acute conditions (e.g., depression, anxiety), or perhaps less often for patients who may be seen infrequently for maintenance of therapy goals.

Psychologists are encouraged to measure treatment process and outcome in multiple domains, including affective, cognitive, and behavioral domains.

When appropriate, psychologists are encouraged to enlist the assistance of other disciplines (e.g., nurses, nursing aides, rehabilitation clinicians) to observe for progress in these domains as well.

When using these observers as part of a patient's care, psychologists provide an appropriate level of training in data gathering in order to obtain the most valid and reliable data possible.

Psychologists are encouraged to understand that 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 worsening of symptoms, then treatment can be reinitiated or the frequency increased again.

D. Documentation

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

V Ethical Issues

A. Informed consent

Psychologists are encouraged to be knowledgeable of informed consent issues as applied in LTC facilities.

Informed consent for psychological services is based on the (a) legal competency of the patient to make informed decisions regarding mental health care, (b) patient's decision-making capacity regarding consent to psychological services, and (c) availability of family members or other potential surrogates should the patient have diminished capacity.

For a competent/capacitated resident without significant cognitive impairment, before any psychological services are rendered, psychologists strive to provide a clear statement of the condition warranting psychological services, what services are to be rendered, and the anticipated consequences of accepting or refusing services.

For a patient declared legally incompetent, psychologists strive to provide the legally recognized decision-maker with 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 the decision-maker must give informed consent, psychologists also attempt to help the patient understand the rationale for treatment (within the limits of the patient's cognitive abilities) and to obtain the patient's assent (Bush, Allen, & Molinari, 2017).

For a patient with significant cognitive impairment who has been assessed and determined to be without decision-making capacity to address the relevant issue, but who has not been declared legally incompetent, psychologists endeavor to work with the interdisciplinary team to identify a surrogate decision-maker, where permissible, and to provide the rationale for treatment to that party. Surrogate decision-making options may include a previously appointed healthcare proxy,

agent per a durable power of attorney for healthcare, and in many states, the next of kin or other close relation may provide consent. (American Bar Association Commission on Law and Aging – American Psychological Association, 2008). Psychologists should have a clear understanding of the relevant decision-making law in their jurisdiction and of the impact on privacy and disclosure to surrogate decision-makers. Even when a surrogate decision-maker is utilized, psychologists attempt to help the patient understand the rationale for treatment and obtain their assent.

Consent for services is not required if the patient is considered dangerous to self or others (as defined by applicable jurisdictional law).

Psychologists who are employees of the facility, 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. Nevertheless, psychologists are encouraged to provide to the patient a clear statement of the planned psychological services and the anticipated benefits and risks of the services, and attempt to obtain the patient's assent. Consulting psychologists who are not part of the staff institutional treatment team must obtain separate informed consent as previously described.

B. Confidentiality

Psychologists strive to ensure that the rights to confidentiality, state and federal laws, and ethical principles regarding psychological services are observed, as they would be for all other patients. They are encouraged to take reasonable steps to safeguard patient information from unauthorized disclosure without the consent of the patient and/or their decision-maker.

Prior to beginning professional services, psychologists are encouraged to discuss limits of confidentiality, including who has the authority to release and access information (e.g., designated health care agent, guardian, or conservator), and exceptions to confidentiality, such as danger to self or others, and mandatory abuse reporting in clear understandable language (oral or written as appropriate) at a suitable health literacy level.

Psychologists are encouraged to discuss with the patient or legal guardian communication that they will have with the facility/treatment team, and accessibility of documentation by treatment team members.

If psychotherapy notes are kept separately from the facility medical record, psychologists are encouraged to arrange for security of the patient record and to ensure that maintenance of such documentation is consistent with relevant privacy laws and facility practices to the degree possible. If separate psychotherapy notes are maintained the facility medical record must include the location of this confidential information.

C. Privacy

Residents in LTC facilities are entitled to the right to privacy as noted in the Code of Federal Regulations as it pertains to LTC facilities (42 CFR 483.10 and relevant State law).

Psychologists should be familiar with facility and state regulations regarding treatment privacy in their geographical areas.

A patient's right to privacy has implications related to the provision of psychological services in LTC facilities. However, meeting the privacy expectations in LTC can be difficult at times due to environmental factors often encountered in these settings. Common barriers to privacy often include a resident sharing a room with another resident, residents having motor impairment limiting their ability to easily leave their room and relocate to a private area, and staff abruptly entering the resident's room while psychological interventions are being offered. In LTC settings, patients often reside in the same space where they receive psychological services and, therefore, their private mental health information may be overheard by other residents, staff not directly involved in their care, and visitors to the facility. It is also common for facility staff to interrupt while psychological services are being provided. Patients may want to engage in psychotherapy in areas where privacy is limited (e.g., the facility hallway, dining room, at a nurse's station, or in the lobby of the facility). However, when patients' insight into the importance of privacy related to their mental health information may be limited, psychologists are encouraged to discuss with their patients the importance of privacy and to make efforts to find a more private area to conduct psychological services.

Psychologists strive to understand that conducting psychological services in LTC settings is different than providing outpatient services, where patients come to a private office and then return to their home, and their private matters are restricted to the office setting.

Psychologists work to ensure that sensitive patient information disclosed during the psychotherapy process is kept private from individuals with no right to the information.

Psychologists are encouraged to consider carefully what information is placed in a facility medical record versus psychotherapy notes and how such information is shared or withheld.

Psychologists are encouraged to provide education to LTC facility staff members regarding the importance of allowing patients to have privacy during psychological treatment. Additionally, they are encouraged to be creative in meeting the privacy guidelines. Some LTC facilities provide private consulting rooms that can be utilized for conducting psychotherapy or psychological assessments. 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 semi-private room, the psychologist may choose to draw the curtain between beds to provide some level of privacy.

To avoid unnecessary intrusions during treatment, psychologists may choose to place a "do not disturb" or similar sign on the patient's door during session. If a patient is being relocated to a different part of the facility for increased privacy, it is ideal to notify nursing and/or other facility

staff so they know where the patient can be found and thereby do not unnecessarily interrupt the session.

Psychologists should adhere to HIPAA and other relevant jurisdictional laws regarding obtaining consent and sharing personally identifying information, such as names and/or images, of their patients on personal social media sites. Due to inability to control resident information placed on websites or social media (i.e., information may be re-posted or copied by third parties), psychologists are discouraged from posting resident information. If they choose to do so, they take steps to ensure compliance with relevant state and federal laws and ensure that this issue is addressed in consent documentation.

To maintain privacy of sensitive patient information in electronic health records, psychologists strive to disclose the least amount of confidential information necessary to achieve the desired purpose, while still attempting to meet requirements by payer sources.

D. Conflict of Interest

Psychologists are encouraged to be familiar with potential conflicts of interest that can arise in LTC settings. These may include those of the resident, family members, or other involved persons, decision-makers who may or may not support the patient's known wishes or best interests, facility priorities that do not align with the patient's best interests, or the requirements of third-party reimbursement sources. In such cases, psychologists are encouraged to make every effort to resolve conflicts in the best interest of the patient.

Psychologists strive to ensure that referrals received from a LTC setting primarily serve the best interest of the resident and address an appropriate psychological need.

Psychologists strive to ensure continuity of care. If care is interrupted due to payment issues, institutional barriers, or other nonclinical reasons, or if the resident is discharged and psychologists are unable to continue services, psychologists try to make reasonable efforts to plan for facilitating continued services.

E. Advocacy

Psychologists are encouraged to work with institutions and staff to support residents' rights including having intimate relationships (for both heterosexual and LGBT residents), respecting sleep and meal schedules, food choices, and roommate preferences, rights to refuse treatments, etc.

Psychologists comply with mandated reporting laws and additionally are encouraged to advocate for persons possibly affected by abuse, neglect, or related trauma.

Psychologists are encouraged to advocate for residents' rights, access to mental health services, and use of evidence-based psychological services to reduce emotional distress and improve the

quality of residents' life (see APA Practice Organization's *Advocacy*:
<http://www.apapracticecentral.org/advocacy/index.aspx>.)

When mental health services are not being delivered or are being provided in a manner inconsistent with standards of care or evidence-based practices, psychologists strive to educate facility staff, other care providers, and family members to improve the delivery of care for residents (see *Guidelines for Psychological Practice in Health Care Delivery Systems*: <https://www.apa.org/pubs/journals/features/delivery-systems.pdf> and *Guidelines for Psychological Practice with Older Adults*: <http://www.apa.org/pubs/journals/features/older-adults.pdf>).

As decision-making and other cognitively based capacities are related to the exercise of rights and potential justifications to restrict rights, psychologists may assist by assessing relevant cognitive, emotional, and other psychological capacities related to the exercise and restriction of rights.

In cases where restriction of rights leads to emotional distress, psychologists may provide psychological support as needed.

Conclusion

Psychologists, if appropriately -trained, are well suited to address the diverse needs of residents across the continuum of LTC settings. This may include services for individuals outside more traditional institution-based skilled-nursing or residential care settings, and across a broad range of ages and disabilities. It is the position of PLTC that ultimately, provision of psychological services in LTC will move from being setting-specific to being based on LTC needs reflecting the diversity of LTC patients.

Guidelines for psychological practice for any population are always works-in-progress given an evolving research base, which is the first step towards evidence-based services. It is anticipated that the current guidelines will provide direction for psychologists who want to serve this population competently; such psychologists should identify their training needs and conduct appropriate remediation before engaging in clinical activities in LTC. It is also hoped that other mental health professionals will find these guidelines applicable in overseeing their discipline's specific behavioral healthcare services to older adults. It again is emphasized that these guidelines are aspirational rather than prescriptive in nature. They focus on institutional LTC, but most of them can be applied easily in community LTC settings (e.g., geriatric day care; in-home hospice). Long-term care psychology is a relatively new area with few specialists, so it is expected that these guidelines will continue to be revised as clinical experience and research findings mature in an ever-changing healthcare environment.

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