

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

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To address concerns about limited training of psychologists working in long-term care (LTC) facilities, the Psychologists in Long-Term Care (PLTC) organization published Standards for Psychological Services in Long-Term Care Facilities (Lichtenberg et al., 1998). The expanding evidence base for knowledge and skills, the increasing diversity of LTC residents, and the complexity of presenting problems have compounded the guidance psychologists need when providing services in this setting. In this article, the PLTC Guidelines Revision Task Force presents PLTC guidelines based on the original prescriptive PLTC Standards. The content of the PLTC Standards was updated and the format changed from prescriptive standards to aspirational guidelines. We begin with general guidelines regarding knowledge and skills in LTC (education and training, understanding of LTC systems, end-of-life care), followed by specific guidelines covering the basic psychological service activities in LTC (referral, assessment, treatment, ethical issues, and advocacy). The PLTC Guidelines are designed to provide direction for psychologists who work, or plan to work, in LTC and to guide continuing education pursuits.


Public Significance Statement

It has been 25 years since the publication of the PLTC Standards of Practice for Psychologists in Long-Term Care. The composition of the long-term care (LTC) population has changed, and the need for aspirational guidelines for psychologists to enter the LTC field has grown in increasing importance. The authors hope that these guidelines will serve as a guide to training needs and optimal mental health practice in LTC settings.

Keywords: psychologists, long-term care, behavioral health, guidelines, training

This article was published Online First April 2, 2020.

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Long-term care (LTC) may be defined as the care provided to individuals with severe or multiple medical problems that interfere with daily living and who require prolonged skilled nursing care, often delivered in an institutional setting (e.g., skilled nursing facilities, Department of Veterans Affairs [VA] community living centers, assisted living facilities). In 1995, the organization known as Psychologists in Long-Term Care (PLTC) began discussions regarding the development of initial standards for the practice of psychology in LTC. The focus was on sound practices in geropsychology, primarily in skilled nursing facilities. The impetus for this project was a growing awareness of the apparent lack of geropsychology training among many clinicians who were expanding their practices into LTC, in which even “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” (Lichtenberg et al., 1998, p. 122). PLTC members determined that both clinicians and LTC facility administrators needed basic standards to guide the appropriate delivery of psychological services in LTC settings.

When the Standards for Psychological Services in Long-Term Care Facilities (hereafter, “PLTC Standards”) were published (Lichtenberg et al., 1998), the target audience was psychologists providing, or planning to provide, services in LTC settings. The PLTC Standards

were prescriptive in nature, noting what was expected of psychologists working in LTC. With the current revision, the PLTC Standards changed to the PLTC Guidelines for Psychological and Behavioral Health Services in Long-Term Care Settings (hereafter, “PLTC Guidelines”) to offer guidance rather than to mandate requirements. Association Rule 30–8.1 Standards and Guidelines of the American Psychological Association (APA; APA, 2019) offers a useful and relevant distinction between standards and guidelines, which informs the present PLTC Guidelines. Standards “include any criteria, protocols or specifications for conduct, performance, services or products in psychology or related areas, including recommended standards. Standards are considered to be mandatory and may be accompanied by an enforcement mechanism” (APA, 2019). In contrast, guidelines “include pronouncements, statements or declarations that suggest or recommend specific professional behavior, endeavor or conduct for psychologists or for individuals or organizations that work with psychologists. In contrast to standards, guidelines are aspirational in intent” (APA, 2019). The current PLTC Guidelines retain the basic framework of the PLTC Standards but make substantive modifications to the content. These modifications are based on the move from standards to guidelines, changes in the population of residents of LTC settings, and the evidence base for knowledge and skills necessary to function competently in LTC settings.

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THE AUTHORS WOULD LIKE TO ACKNOWLEDGE William Haley, Brain Carpenter, and Ardis Hanson for their careful reviews of the final versions of this article. We also would like to acknowledge the Psychologists in Long-Term Care Board for their guidance in the development of these guidelines.

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Need for Guidelines

Prevalence of Mental Health Conditions in LTC

LTC is a rapidly evolving and growing domain of practice for psychologists. It has long been known that mental health problems are rife in LTC settings. Between 25% and 50% of assisted living facility residents carry a psychiatric diagnosis (Becker, Stiles, & Schonfeld, 2002; Rosenblatt et al., 2004). As many as 25% of nursing home residents suffer from major depression and as many as 82% report depressive symptoms (Seitz, Purandare, & Conn, 2010). In addition, studies of anxiety disorders in nursing homes estimate a prevalence between 5% and 5.7% (Creighton, Davison, & Kissane, 2016). Persons who have a wide range of neurocognitive disorders are also frequently encountered in LTC settings, with studies suggesting that almost two thirds of nursing home residents exhibit cognitive impairment (Gaugler, Yu, Davila, & Shippee, 2014), and 70% of residents in assisted living facilities are diagnosed with dementia (Zimmerman, Sloane, & Reed, 2014).

Changing Resident Population in LTC

More than 20 years after the LTC Standards were published, aspects of professional geropsychology practice in LTC settings have changed significantly, reflecting shifts in the characteristics of LTC residents. The prevalence of dementia increases with age, with an estimated 5% prevalence of dementia among individuals between the ages of 71 and 79, and over 37% for those 90 and over (Plassman et al., 2007). Americans are now living longer, resulting in a dramatic increase in the numbers of the oldest-old (85+ years old), who are the highest consumers of LTC services (Federal Interagency Forum on Aging-Related Statistics, 2016) and who will increasingly need help with the neuropsychiatric symptoms associated with dementia. In addition, younger persons (e.g., those with traumatic brain injuries [TBI], disabilities, chronic medical and psychiatric conditions) are the fastest growing segment of the institutional LTC population (Harris-Kojetin et al., 2019; Shapiro, 2010). Together with approximately 12% to 14% of nursing home residents, more than 40% of the individuals who need care across all LTC settings are younger than 65 years of age (Harris-Kojetin et al., 2019; Shapiro, 2010). LTC residents include children and adolescents with intellectual and developmental disabilities, young adults with congenital degenerative conditions or acquired brain injury, and people with HIV/AIDS (Singh, 2010), as well as an increasing proportion of short-term residents who receive intensive rehabilitation therapies with the goal of returning to their private residences.

Additional challenges with regard to behavior management in LTC settings are posed by individuals with progressive dementias, with a broad range of neurological conditions (e.g., seizure disorders, Parkinson's disease), and with serious mental illnesses (SMIs), as individuals with SMIs are younger than "typical" LTC residents. In this latter category, using a narrow definition of SMIs (i.e., bipolar disorder and schizophrenia), data collected by the Centers for Medicare and Medicaid Services indicate that the prevalence of SMIs in nursing homes is approximately 20% (PASRR Technical Assistance Center, 2018). Studies have also suggested that 12% of residents in assisted living facilities are

diagnosed with a psychotic disorder (Rosenblatt et al., 2004). Such changes in the LTC population have triggered a reexamination of the training and skills necessary to address the behavioral health care needs of current LTC residents.

Growing Evidence Base for Psychological Intervention in LTC

There is a growing evidence base for the effectiveness of psychological interventions for older adults in general and in LTC specifically. Research consistently indicates that psychotherapy is effective in the treatment of older adults (Gatz et al., 1998; Raue, McGovern, Kiesses, & Sirey, 2017; Scogin & Shah, 2012; Tavares & Barbosa, 2018). 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; Pary, Sarai, Micchelli, & Lippmann, 2019; Thoma, Pilecki, & McKay, 2015). For the LTC population, the Behavioral Activities Intervention (BE-ACTIV; Meeks, Looney, Van Haitsma, & Teri, 2008) and structured reminiscence interventions reduce depression in nursing home residents (Chiang et al., 2010; Haight, Michel, & Hendrix, 2000). Benefits of such interventions have been found even for those with cognitive impairment (Woods, O'Philbin, Farrell, Spector, & Orrell, 2018). The Montessori tailored approach engages residents with severe dementia (van der Ploeg et al., 2013) and the Staff Training in Assisted Living Residences—Veterans Affairs (STAR-VA) program uses a multicomponent interdisciplinary behavioral approach to effectively reduce challenging behaviors of nursing home residents 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). Evolving best practices, recently described by O'Shea Carney and Norris (2017) and advancing internationally (Molinari & Ellis, 2017), highlight the expanding roles for psychology and opportunities for innovative mental and behavioral health care delivery in LTC settings.

Workforce Shortage in LTC

Although psychologists provide valuable services in LTC settings, there remains a need for more psychologists trained to work in 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 of 65 (APA, 2016). However, approximately 1% of licensed psychologists 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 and supervision from psychologists experienced in LTC regarding the provision of services in such settings. They may consult the guidelines together with the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel et al., 2012) to identify areas of weakness and perhaps focus on their recognized areas of strength until their deficits are addressed. Additionally, there seems to be a need among LTC psychology trainees for guidance regarding professional competence to practice in LTC settings, because a limited number of graduate training programs in professional geropsychology have a focus on LTC.

Growth of the Field

Despite the small percentage of psychologists who identify geropsychology as their main specialty, the field of geropsychology has matured considerably over the past 25 years, as evidenced by the formation of APA Division 12, Section 2 (Society of Clinical Geropsychology [SCG]), in 1993 (Routh, 1994). In 2014, the American Board of Geropsychology became a specialty of the American Board of Professional Psychology, and as of December 2019, 76 psychologists are now credentialed as specialists in geropsychology. Moreover, PLTC, SCG, and the Council of Professional Geropsychology Training Programs have grown in membership over the years, with the latter having 44 member programs in 2019. APA has acknowledged the continued growth and importance of geropsychology in recent years by granting it specialty status through the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology, and by the approval of two geropsychology postdoctoral programs by the Committee on Accreditation.

The seminal geropsychology training framework is the Pikes Peak model for training in professional geropsychology (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009). This model is foundational for training and the development of competency in providing services to older adults in all settings in which psychological services are provided to older adults, including LTC settings. The authors of the Pikes Peak model utilized the 2004 APA Guidelines for Psychological Practice with Older Adults (APA, 2004; revised 2014) to provide a frame of reference for understanding one's readiness to offer services to older adult clients. Those guidelines addressed six categories: (a) attitudes; (b) knowledge; (c) clinical issues; (d) assessment; (e) intervention, consultation, and other service provision; and (f) continuing education (APA, 2004). The Pikes Peak model then added specific core attitudes, knowledge, and skill competencies, attained across different levels of training, to which practitioners and students should aspire for competent practice as geropsychologists. Knowledge of life span development allows providers to inform their assessment, intervention, and consultation through consideration of the needs of adults at different periods of adult development. Recently, the foundational knowledge competencies in geropsychology have been described in detail to assist generalists in enhancing competencies for work with older adults (Hinrichsen, Emery-Tiburcio, Gooblar, & Molinari, 2018).

In the provision of psychological services to the diverse range of LTC residents, including many who are under 65 years of age, many of the other Pikes Peak competencies are applicable. When discussing the complexity of providing psychological services to older adults, the authors of the Pikes Peak model 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" (Knight et al., 2009, p. 206).

In light of the increasing heterogeneity of LTC residents, psychologists in LTC need to be knowledgeable of appropriate evidence-based assessment and treatment for mental disorders and behavioral issues that are common across much of the life span. A recent study by Moye et al. (2019) found that training in a recognized specialty area other than geropsychology (e.g., reha-

bilitation psychology, health psychology, neuropsychology) yields some knowledge and skills relevant for working in specific geriatric settings but does not cover all the Pikes Peak and related competencies necessary for practice in LTC. The authors also found that the number one area in which psychologists want more training is "adjustment to medical illness/disability" (Moye et al., 2019, p. 46), which is an area of particular relevance in LTC. More training in rehabilitation of TBI, in the psychological sequelae of comorbid medical conditions and terminal illnesses, in the life span trajectories of SMIs, and in complex neurological presentations might be desirable especially for those working in specialized LTC sites.

In summary, since the PLTC Standards were disseminated, many changes have occurred in LTC settings, including resident characteristics and other variables. During the same time, the field of geropsychology matured and a robust literature on evidence-based psychological practice in LTC has emerged. There is still strong overlap between the skills of psychologists in LTC and those of geropsychologists in other settings. However, given the heterogeneity of the LTC population demographics, with increasingly diverse age groups and short-stay rehabilitation admissions, competency in geropsychology and adherence to the Pikes Peak model are perhaps best viewed as necessary but not sufficient for delivery of optimal services in LTC. The guidelines supplement the recommendations of the Pikes Peak model specific to LTC.

The PLTC Guidelines outline the foundational and functional knowledge and skills for work in LTC above and beyond competencies necessary in clinical psychology and geropsychology. The intended audiences include psychologists who are currently working in LTC, psychologists who desire to work with LTC residents who are not necessarily older adults, and students who are pursuing the basic LTC foundational and functional knowledge and skills that extend beyond the competencies necessary in geropsychology.

Guideline Development Process

In the fall of 2014, PLTC formed the PLTC Guidelines Revision Task Force, (hereafter "Task Force") to revise the 1998 LTC Standards to reflect current LTC psychological practice and to move away from prescriptive standards to aspirational guidelines. As noted in the previous section, given the diversity of LTC residents and settings and the APA's promotion of guidelines rather than standards, the task force 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. The PLTC Task Force's intention for these guidelines was not to weaken the points made in the standards but rather to encourage practice in LTC settings, and to make the practitioner aware of the burgeoning research in this area to guide delivery of competent services. The Task Force wanted to promote its use as an aspirational guide for students or professionals at any level of training or experience to enable them to recognize their strengths as well as skill deficits for providing LTC services versus standards to which practitioners are to be held accountable. The Task Force also wanted to convey a sense of vibrancy about this field. For example, the "culture-change movement" in LTC is now reflected in nursing home regulatory requirements (Schoeneman, 2016). This movement emphasizes person-centered care and au-

tonomy, promotes hope in aging settings (Thomas, 1999), and brings excitement and the potential for developing creative interventions to those working in the field.

A post was placed on the PLTC listserv to solicit members for the Task Force who would be interested in revising the PLTC Standards. Initially, there were eight members of the Task Force, all of whom were licensed as psychologists. They included the President of PLTC, who is a both nurse and psychologist in independent practice; three academics who have experience both in research and providing services in nursing homes; one person in independent practice in neuropsychology; one neuropsychologist working in the VA system; one VA research psychologist who consulted in a nursing home; and one psychologist working in a county-owned skilled nursing home facility. 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 what would become guidelines rather than prescriptive standards. The revised title also reflects PLTC's focus on both psychological and broad behavioral health services in LTC.

A rationale for a revision of the standards was developed, which included discussion of how psychological practice in LTC had changed over the years. The original emphasis on institutional LTC was retained because psychologists are more likely to practice in nursing homes or assisted living facilities versus community LTC settings. However, with minor variations, the guidelines are largely applicable to all LTC settings (Molinari & Ellis, 2017). For example, home-based primary care psychology providers often work as part of an interdisciplinary team to conduct dementia assessments, provide evidence-based treatments, and address comorbid health conditions in a frail older adult population that is at risk for entering institutional LTC settings (Zeiss & Karlin, 2008).

As a next step, professionals with expertise in the different domains of the guidelines were identified and asked to review and revise the content areas they were assigned. Their suggestions were reviewed by the PLTC Guidelines Revision Task Force, which passed the document on to the PLTC Executive Board for review. In addition, comments by the general PLTC membership were solicited during a conference call. A second revised draft was then circulated to the PLTC Executive Board for final editing before the PLTC Guidelines were formally approved, endorsed, and vetted into their current form. The rest of this article is based in substantial part on the approved PLTC Guidelines. This version will replace the one currently on the website after it is published. By this time, the Task Force has expanded to 10 members. Five of the original members of the Task Force had been replaced by seven other licensed psychologists, and the Task Force now includes two academics who have experience in research and providing services in nursing homes, one psychologist working full-time in a county skilled nursing home facility, three psychologists who conduct independent practice in LTC settings, one psychologist in independent practice in neuropsychology, one psychologist in independent practice in geropsychology, and two psychologists who conduct research, training, and practice with older veterans in the VA system.

The PLTC Guidelines emphasize applied knowledge and skills, and do not address the important but less typical professional activities such as quality improvement and research. The guidelines also do not emphasize specific types of therapeutic services

(e.g., family therapy, couples therapy, group therapy) that potentially could be provided in LTC. For this information, please see general resources in clinical geropsychology and LTC (Lichtenberg & Mast, 2015; O'Shea Carney & Norris, 2017). The guidelines focus on what is unique about the (a) LTC practice population, and (b) LTC settings compared with populations and settings encountered in outpatient mental health, psychiatric hospitals, and in independent practice. LTC residents cope with significant health problems and their sequelae, such as impaired daily functioning, reduced independence, and complications from complex medical regimens. There may be preexisting psychological issues exacerbated by comorbid medical illnesses or residents reeling from trying to cope with their new sense of selves or grieving the loss of their health. LTC settings are communal settings with prominent medical components. Many of the issues addressed in the ethics domain of the guidelines (Guideline 2.4; e.g., informed consent, confidentiality, privacy, conflicts of interest), encountered in nursing homes and, to a lesser degree, in assisted living facilities, occur because of the medical context of the LTC facilities.

In medical settings, psychologists must interface with other health and mental health care professionals (e.g., physicians, physical therapists, social workers, dietitians), who participate in interdisciplinary treatment teams, and coordinate care with physicians and consulting specialists. Nursing and nursing aide staff are crucial for functional assessment and the implementation of behavior management programs. Guidance regarding interdisciplinary collaboration and consultation is embedded in a number of the guidelines domains, especially the Understanding Systems of Care domain (Guideline 1.2). There remains a strong need for interdisciplinary experiential training, and the VA Healthcare System, Institute of Medicine, and APA have taken a lead in providing the resources and models of interdisciplinary care (Karel, Gatz, & Smyer, 2012; O'Shea Carney & Norris, 2017).

Organization of Guidelines

The PLTC Task Force decided to retain most of the same domain headings and format of the original PLTC Standards for the PLTC Guidelines. We begin with general guidelines regarding the basic knowledge and skills (Guideline 1) that address education and training (Guideline 1.1), understanding of LTC systems (Guideline 1.2), and the growing practice area of end-of-life care (Guideline 1.3). This is followed by specific guidelines covering the basic psychological service activities in LTC (Guideline 2) encompassing referral (Guideline 2.1); assessment (Guideline 2.2); treatment (Guideline 2.3); ethical issues of informed consent, confidentiality, privacy, and conflict of interest (Guideline 2.4); and advocacy (Guideline 2.5).

PLTC Guidelines

Guideline 1: Basic Knowledge and Skills

The Pikes Peak model of training and the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel, Holley, et al., 2012) are useful for identifying core knowledge and skill competencies needed to provide services to older adults in LTC and across the training continuum for determining whether additional education and training (Guideline 1.1) are necessary. For

example, the Pikes Peak model emphasizes the “conceptual basis of professional geropsychology in life span developmental psychology” (Knight et al., 2009, p. 208), and the importance of contextual (e.g., LTC, home-based care) and systemic issues in understanding the comorbidities of late life and in guiding geropsychological assessment and interventions. The Pikes Peak Geropsychology Knowledge and Skill Assessment Tool is a competency evaluation and rating tool, with ratings that correspond to Novice, Intermediate, Advanced, Proficient, and Expert that can be used for self-evaluation or evaluation of students and professionals across the knowledge and training continua. For example, Pikes Peak model LTC-related items include “Adaptations of interventions to particular settings (e.g., focus on staff education and behavioral, environmental interventions in long-term care settings)” (see Pikes Peak model Intervention Knowledge: IV-A-3c) and “Intervene in common geriatric settings (e.g., home, community centers, nursing homes, assisted living facilities, retirement communities, medical clinics, medical and psychiatric hospitals)” (see Pikes Peak model, Intervention Skills: IV-B-6a). It is hoped that with the growing use of the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool in graduate school, internship, and postdoctoral programs, and the dissemination of these PLTC Guidelines by their publication and placement on the PLTC website, students and licensed psychologists interested in LTC will have basic resources to guide their training and remediation efforts. These Guidelines will continue to be revised as clinical experience and research findings advance and as LTC mental health activities evolve in an ever-changing health care environment.

Guideline 1.1: Education and training. Psychologists are encouraged to possess the education, training, and/or supervised experience relevant to the populations served and settings in which they practice.

Psychologists gain additional expertise if they encounter residents who have conditions outside the scope of their current professional competence. Psychologists are encouraged to engage in outside expert consultation, or otherwise obtain established scientific and professional knowledge, as needed, to meet the needs of the residents, caregivers, and institutions they serve.

Guideline 1.2: Understanding systems of care. Psychologists strive to understand the LTC system. In particular, psychologists strive to recognize how to work effectively within LTC organizational structures and how to foster appropriate transitions from one LTC setting to other facilities and residences. Psychologists are encouraged to have an understanding of skilled nursing homes memory care units, hospice/palliative care, and medical hospitals. Psychologists strive to remain abreast of relevant state and federal regulations, Preadmission Screening and Resident Review (PASRR; PASRR Technical Assistance Center, 2018), and the Olmstead Act (*Olmstead v. L. C.*, 1999).

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, and so forth. Psychologists also are encouraged to understand their role in integrated care, 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 and mental health needs). To provide the proper interdisciplinary care in LTC

settings, psychologists are encouraged to honor the contributions of the major health care disciplines (e.g., nursing, social work, geriatrics, dietitians, occupational therapists, physical therapists, speech and language therapists), skillfully communicate with members of the team, and work collaboratively with them.

Psychologists are encouraged to understand LTC culture, systems, and operations, including becoming familiar with medical terminology, the Minimum Data Set, care planning, and the professional responsibilities of the key leadership and other service providers, including the medical director, director of nursing, registered nurses, licensed practical/vocational nurses, and certified nursing assistants. Participating in interdisciplinary collaborative processes when possible and understanding the roles of other treatment team members, such as rehabilitation therapists, dietitians, and other specialists, also promotes optimal resident care.

Psychologists are encouraged to support and educate staff in person-centered care. The Centers for Medicare and Medicaid Services criteria (see *Centers for Medicare and Medicaid Services*, 2019) are helpful in determining the extent to which resident needs are being met by the facility.

Guideline 1.3: End-of-life issues and care. With the inclusion of hospice/palliative care services in LTC settings (Dobbs, Kaufman, & Meng, 2018), psychologists are encouraged to recognize that they may be increasingly called upon to address end-of-life issues for residents and their families.

Psychologists strive to understand themes in therapy that often arise at the end of life, such as (anticipatory) grief, existential distress, processing losses (interpersonal, functional, identity, etc.), and legacy building.

Psychologists are encouraged to understand that psychological distress can exacerbate one’s experience of “total pain” (physical, psychological, spiritual, and/or existential pain). Psychologists strive to recognize that effective pain management often requires an interdisciplinary approach that includes incorporating psychologists trained in behavioral pain management (Wandner, Prasad, Ramezani, Malcore, & Kerns, 2019).

Psychologists are encouraged to provide evidence-based interventions as needed to residents living with life-limiting illness and to their family members and friends during end-of-life care. Psychologists strive to make these interventions appropriate for end-of-life issues and to modify them to address the unique needs of the resident’s life context (Haley, Larson, Kasl-Godley, Neimeyer, & Kwilosz, 2003). They also strive to understand the potential shortcomings of such modifications.

Psychologists strive to participate in care conversations for those with serious medical problems regarding goals of care, treatment options, available services, and other end-of-life issues (U.S. Department of Veterans Affairs, 2018).

Psychologists strive to understand and integrate aspects of residents’ cultural identity and familial concerns related to death and dying into their therapy. Cultural considerations specific to end-of-life may include beliefs about aging, illness (e.g., etiology, treatment), the dying process, and cultural traditions, ceremonies, and beliefs after death (LoPresti, Dement, & Gold, 2016).

Psychologists are encouraged to be aware of the legal, ethical, religious, and clinical issues regarding voluntary refusal of life-sustaining measures by a cognitively intact person or by proxy (advance directive/agent/surrogate) and assisted dying (Pope &

West, 2014). For further guidance, see the latest APA resolution on this topic (APA, 2017).

Psychologists may participate with other health care disciplines in the education of LTC residents and their families regarding various end-of-life issues (e.g., advance care planning, completion of Physician's Orders for Life-Sustaining Treatment forms, palliative care, hospice, code status, and surrogate decision making; Clayton et al., 2007).

Guideline 2: Basic Psychological Service Activities

Basic psychological service activities in LTC include referrals (Guideline 2.1), assessment (Guideline 2.2), treatment (Guideline 2.3), and the need to address ethical issues (Guideline 2.4) and to conduct advocacy (Guideline 2.5) for residents in LTC settings.

Guideline 2.1: Referral for psychological services. Various parties (e.g., facility social workers, nurses, physicians, family members) may refer residents of LTC facilities for psychological services. Although many facilities require a physician's order for psychological services, other means of referral such as a resident requesting services may be appropriate.

Examples of common reasons for the need for psychological services include (a) changes in cognitive functioning; (b) nonadherence with medical treatments; (c) behavior or personality changes; (d) unmanaged pain; (e) signs of depression; (f) signs of anxiety; (g) grief reactions; (h) adjustment-related frustration or anger; (i) aggressive, combative, or agitated behavior; (j) inappropriate sexual behavior; (k) psychotic symptoms; or (l) relationship problems with family, staff, or other residents.

Psychologists are encouraged to provide evidence for the need for psychological services, even if referred by someone else, and to communicate the referral and its rationale to the interdisciplinary team.

Prior to initiating services in their LTC setting, psychologists are encouraged to determine which psychological services are reimbursed, as some reasons for referrals may not meet third-party payer coverage policies (e.g., behavior management for residents with advanced dementia). Psychologists are encouraged to be aware that indirect services, such as those described in the following paragraph, are typically not reimbursed by insurance entities.

In addition to direct clinical services and despite not being reimbursed by third-party payers, psychologists are encouraged to provide various indirect services (such as staff consultation, training, and education) and to participate in interdisciplinary team conferences. Psychologists also provide family consultation and support as needed. Additionally, psychologists are also urged to promote the design and implementation of preventive services and institutional programs, resident-centered care, trauma-informed 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; cf. Carney & Norris, 2017).

Guideline 2.2: Assessment. Psychologists are encouraged to understand the role that sensory impairments (e.g., vision, hearing) may have on the process and outcome of assessment. They strive to adjust the assessment setting (e.g., adjust lighting, reduce glare, increase font size of written stimulus materials, reduce ambient noise) and accommodate residents through modifications in standard testing procedures and interpretation accordingly.

Psychologists are encouraged to use multiple assessment methods when indicated, including reviewing records, interviewing the resident and others who have knowledge of the resident's background and functioning, direct behavioral observation, psychological testing, and electronic monitoring of daytime and sleep activity (e.g., actigraphy).

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, American Psychological Association, and National Council on Measurement in Education (2014).

With regard to cognitive assessment, psychologists are encouraged to determine cognitive strengths and weaknesses. Such assessments commonly cover attention, language, memory, visuospatial skills, processing speed, abstract reasoning, and other executive functions. Psychologists are encouraged to consider and to assess objectively symptom and performance validity when the resident'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 resident and whether the current place of residence is appropriate to meet the resident's needs; (e) planning a program of rehabilitation; (f) assistance with the determination of capacity (e.g., capacity to consent to treatment; capacity to live independently); and (g) improvement of quality of life. Referrals to or consultation with neuropsychologists occur as needed.

Most psychologists have been trained to administer and interpret cognitive screening instruments and many have been trained to administer and interpret various individual tests of cognitive functioning. However, when faced with complex issues or questions regarding cognitive functioning, psychologists are encouraged to refer residents to neuropsychologists or neurologists for more comprehensive evaluation.

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 and cognitive assessment. They may be particularly helpful in the assessment of maladaptive behaviors. Analysis and assessment include 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. More specific functional skills assessment (e.g., decision making, independent living) is an important element of capacity assessment.

Psychologists are encouraged to consider potential psychological manifestations of physical diseases (e.g., anxiety associated with chronic obstructive pulmonary disease) and reactions to a diagnosis of dementia (e.g., depression) in the assessment process. 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 recognize (a) 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, (b) how SMIs and personality disorders may be exacerbated by these changes, and (c) how medical and cognitive comorbidities interact with these emotional conditions to present a complex clinical picture.

Psychologists are encouraged to understand how the possible side effects of medications used to treat physical diseases and mental disorders (e.g., drowsiness caused by antiseizure medications) could be due to inappropriate medication usage (e.g., *American Geriatrics Society Beers Criteria Update Expert Panel, 2019*) and could affect cognitive, behavioral, and psychological functioning.

Psychologists are encouraged to understand the need for non-pharmacological interventions and to provide residents with psychoeducation regarding the adverse effects of some medications that can result in iatrogenic conditions.

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., internal medicine, neurology, physical medicine and rehabilitation) to assist with diagnostic clarification and treatment as needed and to rule out reversible causes of functional impairment, such as medically treatable illness.

Psychologists are encouraged to obtain repeated assessments to aid in the establishment and evaluation of intervention programs, and to guide the treatment process. Serial cognitive assessments should take practice effects into account. 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 such diversity factors and their intersectionality influence residents' relationships with staff and other residents, and whether biases may be affecting residents' care and quality of life.

Psychologists are encouraged to assess social relationships, including positive and negative aspects of social interactions between individuals. Psychologists also are encouraged to assess for the experience of social isolation, because loneliness is associated with diminished mental and physical health across the life span (Beutel et al., 2017).

Guideline 2.3: Treatment. For adequate treatment to occur in LTC, psychologists need to complete a comprehensive treatment plan (Guideline 2.3.a), evaluate the effectiveness of interventions based on the treatment plan (Guideline 2.3.b), and document progress toward treatment goals (Guideline 2.3.c).

Guideline 2.3.a: Treatment plan. Psychologists are encouraged to develop an individualized, evidence-based 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.

Psychologists are encouraged to include in the plan a mental health diagnosis or clearly defined problematic behavior(s) and clearly defined therapeutic goals that take into consideration the personal values, preferences, and unique needs of the resident.

Psychologists are encouraged to specify the treatment that will be used to achieve the short- and long-term therapeutic goals of the treatment plan and the expected benefits and potential risks of the treatment (Blease, Lilienfeld, & Kelley, 2016).

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

Psychologists are encouraged to outline the frequency and expected duration of therapy sessions required to achieve the therapeutic goals when constructing the treatment plan. 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 and that treatment is effective and proceeding as anticipated.

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

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).

Guideline 2.3.b: Evaluation of treatment progress. Psychologists strive to regularly monitor resident progress toward stated goals to determine whether treatment is effective and should be continued, modified, or terminated (e.g., Goodman, McKay, & DePhilippis, 2013). Psychologists are encouraged to measure treatment process and outcome in multiple domains (i.e., affective, cognitive, behavioral).

When appropriate, psychologists are encouraged to enlist the assistance of other disciplines (e.g., nurses, nursing aides, rehabilitation clinicians) to determine progress in these domains. When using such observers as part of a resident's care, psychologists provide an appropriate level of training in data gathering in order to obtain the most valid and reliable data possible.

Guideline 2.3.c: Documentation. Psychologists strive to provide timely and clear documentation of each resident's diagnosis, treatment plan, progress, and outcome as appropriate and in accordance with current ethical and legal standards.

Guideline 2.4: Ethical issues. The major ethical issues psychologists encounter in LTC are informed consent (Guideline 2.4.a), confidentiality (Guideline 2.4.b), privacy (Guideline 2.4.c), and conflict of interest (Guideline 2.4.d).

Guideline 2.4.a: Informed consent. Psychologists are encouraged to be knowledgeable of informed consent issues as applied to LTC facilities. Informed consent for psychological services is based on (a) the legal competency of the resident to make informed decisions regarding mental health care, and if declared incompetent, the availability of a legal guardian; (b) the resident's decision-making capacity regarding consent to psychological services; and

(c) the availability of a durable power of attorney, family members, or other potential health care surrogates should the resident have diminished capacity.

Prior to rendering services, psychologists strive to provide a clear statement of the condition warranting psychological services, what services are to be rendered, the cost of those services, and the anticipated consequences of accepting or refusing services.

For a resident determined by the court system to lack capacity to make medical decisions, psychologists strive to provide the legally recognized decision maker with a clear statement of the condition warranting psychological services, the nature of the services that are to be rendered, and the possible consequences of accepting or refusing services. Although the decision maker is the legal provider of informed consent, psychologists also attempt to help the resident understand the rationale for treatment (within the limits of the resident's cognitive abilities) and to obtain the resident's assent (Bush, Allen, & Molinari, 2017).

For a resident with significant cognitive impairment who has been assessed and determined to be without capacity to address the relevant issue but who has not been declared legally to lack capacity, 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 health care proxy agent per a durable power of attorney for health care, 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 are encouraged to know the legal standards for diminished capacity in the state in which they practice and to understand the implications these standards have for privacy and confidentiality. Even when a surrogate decision maker is utilized, psychologists are encouraged to help residents understand the rationale for treatment and obtain their assent.

Psychologists who are employees of the facility, privileged by the institution to provide services, and covered by a general institutional consent do not need to obtain separate informed consent before implementing services. Nevertheless, psychologists are encouraged to provide to the resident a clear statement of the planned psychological services and the anticipated benefits and risks of the services, and to attempt to obtain the resident's assent. Consulting psychologists who are not part of the staff institutional treatment team must obtain separate informed consent, as previously described.

Guideline 2.4.b: Confidentiality. Psychologists strive to ensure that patients' rights to confidentiality are observed, to the extent possible, in a facility setting. They are encouraged to take reasonable steps to safeguard resident information from unauthorized disclosure without the consent of the resident and/or their decision maker.

Psychologists are encouraged to discuss limits of confidentiality with residents when questions arise and as clinically indicated.

Psychologists are encouraged to discuss with the resident, health care surrogate, or legal guardian anticipated communication that they will have with other parties involved in the resident's care, such as the treatment team, including the accessibility of documentation by treatment team members (privacy issues are covered in the next domain of these guidelines, Guideline 2.4.c).

If psychotherapy notes are kept separately from the facility medical record, psychologists are encouraged to arrange for security of the resident's 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 may include the location of this confidential information.

Guideline 2.4.c: Privacy. Psychologists strive to be familiar with facility and jurisdictional regulations regarding treatment privacy.

A resident's right to privacy has implications for 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 include (a) residents sharing rooms, (b) residents having motor impairment limiting their ability to easily leave their room and relocate to a private area, and (c) staff abruptly entering the resident's room while psychological interventions are being offered. In LTC settings, residents often reside in the same space where they receive psychological services; therefore, their private mental health information may be overheard by other residents, staff not directly involved in their care, and visitors to the facility. Residents may want to receive psychological services in areas where privacy is limited (e.g., the facility hallway, dining room, nurse's station, or the lobby of the facility). However, when residents' insight into the importance of privacy related to their mental health information may be limited, psychologists are encouraged to discuss with the residents the importance of privacy and to make efforts to find a more private area to conduct psychological services.

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. Sensitive personal information that is unrelated to the resident's care is typically omitted from the facility medical record.

As needed, psychologists are encouraged to provide education to LTC facility staff members regarding the importance of allowing residents to have privacy during psychological assessment and treatment services.

Psychologists are encouraged to adhere to Health Insurance Portability and Accountability Act (U.S. Department of Health and Human Services, 1996) and other relevant jurisdictional laws regarding obtaining consent and sharing personally identifying information, such as names and/or images, of their residents on personal social media sites or in any other public venue.

Guideline 2.4.d: Conflict of interest. Psychologists are encouraged to be familiar with potential conflicts of interest that can arise in LTC settings. These may involve (a) the resident, family members, or other involved persons; (b) decision makers who may or may not support the resident's known wishes or best interests; (c) facility priorities that do not align with the resident's best interests; or (d) the requirements of third-party reimbursement sources. In such cases, psychologists strive to resolve conflicts in the best interests of the resident.

Psychologists strive to ensure that referrals received from a LTC facility 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 strive to make reasonable efforts to plan for facilitating continued services.

Guideline 2.5: Advocacy. Psychologists are encouraged to work with institutions and staff to support residents' rights, including having intimate relationships (inclusive of all sexual orientations), and facilitating discussions around other topics that pertain to life in LTC, such as (a) goals of care and end-of-life decisions, (b) respecting sleep and meal schedules, (c) food choices, (d) roommate preferences, and (e) rights to refuse treatments.

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

Psychologists are encouraged to advocate for residents' rights to access mental health services to reduce emotional distress and improve their quality of life. 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 APA, 2014).

Psychologists strive to promote resident rights and to avoid unwarranted restriction of rights by clarifying decision-making capacities through the assessment of cognitive, emotional, and other psychological functioning.

Conclusions

Competent psychologists are well suited to address the diverse needs of residents across the continuum of LTC settings. Such psychologists benefit from the rewards and are able to endure the stresses of work in LTC. It is anticipated that the current guidelines will provide direction for psychologists who want to serve this population competently; such competence begins by identifying training needs and conducting appropriate remediation before engaging in clinical activities in LTC. Indeed, it is hoped that mental health professionals other than psychologists will find these guidelines applicable in overseeing their discipline's specific behavioral health care services to older adults. Other stakeholders (e.g., administrators) may also benefit from using these guidelines to help understand competent psychological practice in LTC settings. However, no attempt is made in these guidelines to address the specific education and training needed to adhere to them. We do not specifically discuss the application of forensic geropsychology to LTC settings; elder abuse; substance abuse; particular medical conditions common in LTC, such as heart disease; or the needs of minority residents. Given the changing demographics in LTC settings, familiarity with the emerging roles of psychologists in LTC (Haley et al., 2003) and published competencies in rehabilitation, health psychology, and neuropsychology is encouraged. Guidelines for psychological practice for any population are always works in progress given an evolving research base, which is the first step toward evidence-based services. These guidelines will continue to be revised as clinical experience and research findings advance and as LTC mental health activities evolve in an ever-changing health care environment.

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Received October 2, 2019

Revision received December 18, 2019

Accepted December 22, 2019 ■