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| **Behavioral Health Services** |
| *Date Implemented:* |  | *Date Reviewed/ Revised:* |  | *Reviewed/ Revised By:* |  |

**Policy:**

It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning.

**Definitions:**

***“Mental disorder”*** is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.

***“Substance use disorder (SUD)”*** is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

***“Non-pharmacological intervention”*** refers to approaches to care that do not involve medications, generally directed towards stabilizing and/or improving a resident’s mental, physical, and psychosocial well-being.

**“*Trauma”*** results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

***“Post-traumatic stress disorder”*** occurs in some individuals who have encountered a shocking, scary, or dangerous situation. Symptoms usually begin early, within three months of the traumatic incident, but sometimes they begin years afterward. Symptoms must last more than a month and be severe enough to interfere with relationships or work to be considered PTSD.

**Policy Explanation and Compliance Guidelines:**

1. Behavioral health encompasses a resident’s whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders.
2. The facility will consider the acuity of the resident population. This includes residents with mental disorders, psychosocial disorders, or substance use disorders (SUDs), and those with a history of trauma and/or post-traumatic stress disorder (PTSD), as reflected in the facility assessment.
3. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident’s goals for care, while maximizing the resident’s dignity, autonomy, privacy, socialization, independence, choice, and safety.
4. Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being.
5. Conditions that are frequently seen in nursing home residents and may require the facility to provide specialized services and supports based upon residents’ individual needs, include, but are not limited to:
	1. Depression – It is not a natural part of aging, however, older adults in the nursing home setting are more at risk than older adults in the community.
	2. Anxiety and Anxiety Disorders – There are many types of anxiety disorders, each with different symptoms. The most common types of anxiety disorders include Generalized Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, Phobias and Post-Traumatic Stress Disorder.
	3. Schizophrenia – Is a serious mental disorder that may interfere with a person’s ability to think clearly, manage emotions, make decisions and relate to others. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40.
	4. Bipolar Disorder – Is a mental disorder that causes dramatic shifts in a person’s mood or energy, and may affect the ability to think clearly.
6. The facility utilizes the comprehensive assessment process for identifying and assessing a resident’s mental and psychosocial status and providing person-centered care. This process includes, but is not limited to:
	1. PASARR screening.
	2. Obtaining history from medical records, the resident, and as appropriate the resident’s family and friends, regarding mental, psychosocial, and emotional health.
	3. MDS and care area assessments.
	4. Ongoing monitoring of mood and behavior.
	5. Care plan development and implementation.
	6. Evaluation.
7. The resident, and as appropriate the resident’s family, are included in the comprehensive assessment process along with the interdisciplinary team and outside sources, as indicated. The care plan shall:
	1. Have interventions that are person-centered, evidence-based, culturally competent, trauma-informed, and in accordance with professional standards of practice.
	2. Provide for meaningful activities which promote engagement and positive, meaningful relationships. Residents living with mental health and SUDs may require different activities than other nursing home residents. The facility will ensure that activities are provided to meet the needs of these residents*.*
	3. Reflect the resident’s goals for care.
	4. Account for the resident’s experiences and preferences.
	5. Maximize the resident’s dignity, autonomy, privacy, socialization, independence, and safety.
	6. Use pharmacological interventions only when non-pharmacological interventions are ineffective or when clinically indicated.
	7. Address any other individualized needs the resident may have related to the mental disorder or the SUD.
	8. Be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition.
8. If a behavioral contract is used, it will only be used with residents who have the capacity to understand it. A contract will only be used as a method of encouraging the resident to follow their plan of care, and not as a system of reward and punishment. The contract will not conflict with resident rights or other requirements of participation.
	1. Resident refusal to accept, or non-adherence to the terms of a behavioral contract, will not be the sole basis for a denial of admission, transfer or discharge.
	2. If a contract is used, it may also address:
		1. The resident’s right to have a leave of absence and the health and safety risks of leaving without facility knowledge or leaving against medical advice (AMA).
		2. Facility efforts to help residents with mental disorder and/or SUD, such as individual counseling services, access to group counseling, or access to a Medication Assisted Treatment program, if applicable.
		3. Steps the facility may take if substance use is suspected, which may include:
			1. Increased monitoring and supervision in the facility to maintain the health and safety of the resident suspected of substance use, as well as all residents.
			2. Restricted or supervised visitation, if the resident’s visitor(s) are deemed to be a danger to the resident, other residents, and/or staff.
			3. Voluntary drug testing if there are concerns that suspected drug use could adversely affect the resident’s condition.
			4. Voluntary inspections, if there is reasonable suspicion of possession of illegal drugs, weapons or other unauthorized items which could endanger the resident or others.
		4. Referral to local law enforcement for suspicion of a crime in accordance with state laws, such as possession of illegal substances, paraphernalia or weapons.
9. All facility staff, including contracted staff and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Education shall be based on the role of the staff member and resident needs identified through the facility assessment. Behavioral health training as determined by the facility assessment will include, but is not limited to, the competencies and skills necessary to provide the following:
	1. Person-centered care and services that reflect the resident’s goals for care.
	2. Interpersonal communication that promotes mental and psychosocial well-being.
	3. Meaningful activities which promote engagement and positive meaningful relationships.
	4. An environment and atmosphere that is conducive to mental and psychosocial well-being.
	5. Individualized, non-pharmacological approaches to care.
	6. Care specific to the individual needs of residents that are diagnosed with a mental, psychosocial, or substance use disorder, a history of trauma and/or post-traumatic stress disorder, substance use disorder, or other behavioral health conditions.
	7. Care specific to the individual needs of residents that are diagnosed with dementia.
	8. Care specific to residents with ethnic, cultural, or religious factors that may need to be considered to meet resident needs, such as activities, food preferences, and any other aspect of care.
10. Facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident, which includes non-pharmacological interventions. Examples of individualized, non-pharmacological interventions to help meet behavioral health needs of all ages may include, but are not limited to:
	1. Ensuring adequate hydration and nutrition (e.g., enhance taste and presentation of food, addressing food preferences to improve appetite and reduce the need for medications intended to stimulate appetite);
	2. Exercise;
	3. Pain relief;
	4. Individualizing sleep and dining routines;
	5. Considerations for restroom use, incontinence and increasing dietary fiber to prevent or reduce constipation;
	6. Adjusting the environment to be more individually preferred or homelike;
	7. Consistent staffing to optimize familiarity;
	8. Supporting the resident through meaningful activities that match his/her individual abilities, interests and needs;
	9. Assisting the resident outdoors in the sunshine and fresh air (e.g. in a non-smoking area for a non-smoking resident);
	10. Providing access to pets or animals for the resident who enjoys pets (e.g. a cat for a resident who used to have a cat of their own);
	11. Assisting the resident to participate in activities that support their spiritual needs;
	12. Assisting with the opportunity for meditation and associated physical activity (e.g. chair yoga);
	13. Focusing the resident on activities that decrease stress and increase awareness of actual surroundings, such as familiar activities; offering verbal reassurance, especially in terms of keeping the resident safe; and acknowledging that the resident’s experience is real to her/him;
	14. Utilizing techniques such as music, art, electronics/computer technology systems, massage, essential oils, reminiscing;
	15. Assisting residents with SUDs to access counseling (e.g., individual or group counseling services, 12-step programs, and support groups) to the fullest degree possible;
	16. Assisting residents with access to therapies, such as psychotherapy, behavior modification, cognitive behavioral therapy, and problem solving therapy; and
	17. Providing support with skills related to verbal de-escalation, coping skills, and stress management.
11. The Social Services Director shall serve as the facility’s contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrists, or neurologists.

**References:**

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) **F740** – Behavioral Health Services. 42 C.F.R. §483.40.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) **F741** – Sufficient/Competent Staff - Behavioral Health Needs. 42 C.F.R. §483.40.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) **F742** – Treatment for Mental/Psychosocial Concerns. 42 C.F.R. §483.40.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) **F949** – Behavioral Health Training. 42 C.F.R. §483.95.