Psychiatric Care in Residential Care Environments

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Introduction

In the USA, 4.2% of individuals 65 years old and older live in nursing homes (NHs) [1]. This estimate does not include older adults living in other proprietary residential environments. Over the past several decades, a spectrum of terms have been coined to describe the various levels of care provided by, and the configurations of, these residential care facilities for older adults including independent living, assisted living, subacute care hospitals, rehabilitative facilities, and retirement communities. In addition to these terms, other terms describing housing options for older adults include senior community, 55 and up community, senior retirement community, senior living community, multilevel senior community, and continuing care retirement community (CCRC). In this manuscript, the term "proprietary residential care environment" is used when referring to all of the above housing options for older adults. If something is unique to a specific housing option, this will be noted. As the older adult population increases, improved understanding of proprietary residential care setting's unique cultural environments will be critical to implementing successful transitions and promoting the health and well-being of older adult patients.

Background

One of the most important distinctions between different proprietary residential care environments is the level of care or support provided. The term retirement community (RT) is an umbrella term which describes a variety of housing options for predominantly independent seniors. An RT is a residential or housing complex that is designed for older adults and is generally age-restricted (e.g., age 55 and older).

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S. H. Koh et al. (eds.), *Diversity in Action*,
https://doi.org/10.1007/978-3-030-85401-0_11

Residents are usually partially or fully retired and able to care for themselves without regular nursing or other routine medical assistance; however, assistance from home care agencies is allowed in some communities. RTs offer shared services, amenities, activities, and socialization opportunities [2].

As defined by the American Association of Homes and Services for the Aging (AAHSA), a CCRC is "an organization that offers a full range of housing, residential services, and healthcare in order to serve its older residents as their needs change over time" [3]. CCRCs are communities that attempt to promote a sense of independence in older adults throughout their later years. Another term used to describe a CCRC is multilevel senior community.

Older adults who cannot or choose not to live independently, may reside in an assisted living facility (ALF). It is important to note, however, that there is no standard definition for the term. In some states where assisted living is not licensed or regulated, the term may be used quite loosely. Facilities in these states may not provide the services and care usually associated with assisted living. In other states, the term is used to describe a specific type of housing option that is licensed and regulated by the state government. There are also specialized ALFs that cater to those living with a dementia illness. Synonyms for ALF include board and care home and, if dementia care is provided, special care unit or memory care unit.

The exact number of older adults living in each type of senior housing across the USA is not available due to the heterogeneity of labels and defining features, as well as the lack of central data collection. In 2017, the not-for-profit senior living organization National Senior Campuses reported over 19,000 senior living units across the USA, up from the 15,500 estimate provided in 1998 by the American Senior Housing Association (ASHA) [4]. Currently, it is estimated that one million Americans live in some type of senior living community, and that number is expected to double by the year 2030 [5].

With advancements in life expectancy, all studies predict an increase in both the number of older adults and in the complexity of their needs. In fact, the fastest-growing segment of the US population is the group of individuals older than 85 years. The 85-and-older age group is expected to increase from about three million in 2009 to more than 18 million in 2050 [6]. What's more, projections for the year 2050 predict that approximately 40% of the older population will belong to racial or ethnic minorities [7].

Psychiatric Illness in Residential Care Environments

In the early 1980s, work by the National Citizens' Coalition for Nursing Home Reform, a consumer advocacy group concerned about substandard care in NHs, emphasized residents' rights and the importance of implementing resident assessments. Its Consumer Statement of Principles for the Nursing Home Regulatory System, released in 1983, was endorsed by more than sixty national organizations, presented to the US Department of Health and Human Services, and distributed to all congressional offices [8]. Several of the major issues raised about the quality of NH care were related to its psychiatric aspects; physical and chemical restraints

were inappropriately used to control residents' behavior, and psychiatric disorders, primarily depression, were undertreated [6]. In fact, epidemiological studies between 1986 and 1993 uniformly reported high prevalence rates for psychiatric disorders among NH residents [9]. The prevalence of psychiatric disorders among persons newly admitted to a proprietary chain of NHs was found to be 80.2%. In all studies, the most common psychiatric disorder was dementia, with prevalence rates of 50–75% and up to 30% of residents exhibiting behavioral problems [9]. To date, ALFs have not been studied as extensively as NHs, and as described above ALF, licensing or regulation varies by jurisdiction.

Despite the difficulties associated with methods and measurement, evidence to date suggests that quality of life in residential care community environments for older adults is largely determined by the presence of mental health problems and one's subjective sense of well-being [10]. Research also suggests that both the individual's cultural identity, the sensitivity of the treating team toward this identity [11], and the culture of the residential care environment [12] can significantly impact the mental health and perceived quality of life of older adults living in a residential care home. As a result, geriatric psychiatrists play an integral part in the care of older adults residing in NHs and other proprietary residential care environments. The role of geriatric psychiatrists includes advocating for the patient to ensure that they receive optimal care, including appropriate psychiatric treatment. Each resident/patient needs a clinically comprehensive, culturally sensitive, and individualized assessment and treatment plan which addresses medical as well as social and environmental factors as potential contributors to mental health problems. Close monitoring to assess treatment responses and to prevent unwanted side effects is also essential. The 1980's alarm bells warning about NH's low quality of care inspired a series of reforms, public policies, individual initiatives, and innovations which aimed to create and improve the existing practices and standards of care. The movement toward *person-centered care* has been slowly gaining ground in these settings ever since. Still, more needs to be done to improve the health and well-being of older adults living in various residential living environments.

In addition to ensuring comprehensive and individualized care, geriatric psychiatrists and others involved in caring for older adults in proprietary residential living environments are strategically positioned to advocate at various levels of healthcare and community systems. Specifically, advocacy efforts are important within insurance companies, organizations involved in providing housing to older adults, systems of healthcare, government programs, and policy and regulations. Issues include improved architecture which reflects universal design concepts, implementation of new and innovative psychosocial programs, formulation of institutional policies and procedures for assessment, care delivery, training and educating care providers, and monitoring the quality of care being provided in various settings [6, 9]. The education and training that is needed by those who help provide care to older adults living in residential care environments includes knowledge, understanding, humility regarding the cultural identities and characteristics of the individuals for whom they care, awareness of the culture and atmosphere of the residential living environment, and appreciation for the complex intersections of the two. This becomes especially

important when addressing situations where conflict arises and may diminish the patient's quality of life.

Some of the cultural aspects and challenges in care are similar across the various housing options for older adults, and some are unique to the specific type of living environment. The case vignette and ensuing discussion are intended to depict the current landscape and challenges a geriatric psychiatrist may face when caring for older adults in proprietary senior living environments.

Vignette

Mr. X is a single 84-year-old Asian male who has been residing in an ALF. He moved to an ALF after careful consideration and with the support of his nephews. He was feeling very lonely at home and struggled to care for himself with limited support and social interactions, other than occasional visits from his nephews. His medical history is notable for hypertension, diabetes, and an old stroke with minimal residual symptoms. He had no past history of psychiatric illness.

Upon arrival to the ALF, Mr. X's mood improved. Staff members described him as socializing well with other residents and, overall, being a positive addition to the community. A few weeks after he moved in, however, Mr. X's nephews contacted the facility director in distress following a visit with their uncle. They requested an urgent psychiatric consultation due to concerns after observing their uncle's unusual disinhibited sexual behaviors and aggression toward other residents. The medical director of the ALF, who was also the patient's primary care provider (PCP), prescribed Mr. X clonazepam to control these problem behaviors while awaiting the psychiatry consultation.

– *A – Is clonazepam a good choice in this case? Are benzodiazepines commonly prescribed for older adults living in a residential care environment? What does the law say about benzodiazepines and antipsychotic prescriptions for older adults?*

Shortly after, Mr. X suffered from a fall overnight and was sent to the emergency department (ED). Imaging revealed no fractures, but his urine analysis indicated a urinary tract infection (UTI). The patient was diagnosed with delirium secondary to his UTI. After Mr. X had spent 12 hours in the ED, he returned to his ALF with an oral antibiotic prescription, and clonazepam was discontinued. Mr. X's nephews could not help asking themselves if this time-consuming and costly visit could have been prevented.

– *B – What personal characteristics make Mr. X more prone to an ED visit?*

Mr. X's nephews were furious about the incident and its subsequent consequences. They blamed the ALF for the delay in diagnosis of the UTI and the associated delay in medical management. Without consulting Mr. X, who was still recovering from delirium, the nephews decided to transfer him to a NH.

– *C – What are the advantages and disadvantages of this decision? What differentiates a NH from an assisted living community?*

Mr. X remained slightly confused and his recovery proceeded slowly in his new environment. He had trouble adapting to his windowless room and smaller bathroom. His mood was low and he did not engage with other residents or staff members. He was often verbally abusive toward staff. At times, he remained disoriented and forgetful of recent events and names. He also developed new-onset urinary incontinence. Staff members accused him of being purposefully incontinent of urine.

– *D – How can we explain Mr. X's behavior? Could his incontinence be an act of protest instead of the symptom of a medical problem like benign prostatic hypertrophy?*

A neuropsychology referral took place and psychometric tests revealed cognitive impairments consistent with the diagnosis of major neurocognitive impairment due to Alzheimer's disease. Donepezil was suggested to slow the progression of his symptoms. Mr. X rejected the diagnosis and showed no insight into his deficits and limitations. His nephews also had trouble coming to terms with the patient's dementia diagnosis, and they did not wish to start medication for what they believed was a normal process of aging.

– *E – Was there a common cultural belief behind Mr. X's and his nephews' reluctance to accept the recommendation for treatment with donepezil?*

Mr. X was uncooperative whenever assistance with activities of daily living was needed. Up to four staff members were required to assist him with personal hygiene and toileting except when J, a nursing assistant, was on duty. Mr. X had slowly begun to trust J and was less distressed and agitated in his presence. J is from Portugal and he enjoyed talking to Mr. X about his travels in Asia. He once brought him traditional Thai food for lunch, and Mr. X was overjoyed.

– *F – What made J different than the other staff members? Could J's approach be adopted by others?*

The NH director noticed J was more successful than other staff members at engaging with different residents in the ALF, including Mr. X. With the director's approval, J tried to provide his co-workers some pointers about how to approach residents with different racial, ethnic, or cultural backgrounds. Initially, J faced a lot of resistance, especially from registered nurses.

– *G – What could be behind the resistance of the RNs, the low attendance at J's presentations, and the limited engagement of some of the staff members during J's workshops?*

One day while assisting Mr. X with personal care, Mr. X made inappropriate sexual comments. He described his desire for intimacy and his yearning for human contact. J set boundaries with Mr. X who apologetically noted he had been lonely and isolated for a long time.

– *H – Do NH residents maintain their libido and interest in intimacy?*

When queried, Mr. X revealed his preference for men and that he identified as homosexual all his life. According to him, no staff member at the different residential placements had bothered to ask him about his sexual orientation. As a result, he did not mention this to others due to his concerns that he would experience homophobia, feel judged, be rejected and not receive the same quality of care as others.

– *I – What made Mr. X so reluctant to share his sexual orientation? How can we address his fear of stigma and discrimination on an institutional level?*

Despite receiving better medical care at the NH, Mr. X insisted on returning to the ALF where he had originally moved and where he was allowed to have his own furniture and personal belongings. At first, his nephews were shocked by this decision. They were concerned about his care and always thought of the ALF as a "progressive crazy house for the elderly," remembering an older woman wandering around barefoot in nightwear, carrying purses and dolls, and talking to herself. Mr. X explained he felt much more at home there, more respected, and more heard. Mr. X's nephews eventually agreed and respected his wishes.

– *J – What makes the person-centered care philosophy and approach so successful?*

Case Discussion and Recommendations for Optimal Treatment

– *A – Pharmacological treatment of behavioral disturbances experienced by older adults living in residential care environments: undertreating or overtreating?*

National concerns about inadequate and inappropriate care for older adults living in residential environments have focused on the overuse of psychotropic drugs in NH residents, especially the misuse of these medications as "chemical restraints" to control patient behaviors [6, 8]. Studies in the 1970s and 1980s reported that approximately 50% of residents had orders for psychotropic medications, with 20–40% being given antipsychotic drugs, 10–40% given anxiolytics or hypnotics, and 5–10% given antidepressants [9]. These prescribing habits were deemed dangerous due to the multiple adverse effects associated with these medications.

In 1987, Congress mandated stricter regulations to reduce unnecessary drug use as part of the Omnibus Budget Reconciliation Act. The first set of regulations, implemented in 1990, focused on antipsychotic drugs, which often were

used to control the behavior of NH residents despite concerns about adverse effects (e.g., anticholinergic effects, orthostatic hypotension, extrapyramidal symptoms, and ventricular arrhythmias) and lack of efficacy [13]. The second set of regulations, implemented in 1992, focused on benzodiazepines, which were used routinely despite their association with hip fractures, confusion, and other serious adverse effects [14]. These changes in regulations and policies did inspire some improvements in prescribing practices moderated by medication type and setting. A study evaluating NHs responses to those regulations revealed a marked reduction in antipsychotic drug use but little change in the benzodiazepine prescription trends despite the 1992 regulations. Adoption of the new regulations was found to be significantly greater in facilities with a high score on "resident-centered care philosophy" than in those with a low score. The term "resident-centered care philosophy" describes beliefs and norms that emphasize individualized assessment and psychosocial care, avoidance of restraints, and multidisciplinary collaboration. Reduction in psychotropic drug use was greater in communities that had an organizational culture that was compatible with this philosophy [12, 15, 16].

Despite the federal regulations, unique NH settings and practices played a role in medication prescribing trends. Psychiatric medication overprescribing was not found in all NHs. Some studies found that rural nursing homes were consistently under-prescribing psychotropics, which led to suboptimal treatment of depressive, psychotic, and disruptive behaviors. Under-prescribing was associated with the commonly found limitations encountered in rural long-term care settings, such as reduced availability and accessibility of health professionals and services [17]. Tribal NHs are a commonly referenced example as they are mostly located in rural areas, often have challenges in access and identification, and therefore reduced pharmacotherapy [18, 19].

Over half of residents in senior communities have a diagnosis of dementia, and many have associated behavioral disturbances [9]. There are a number of published sources that outline the proper assessment and treatment of behavioral symptoms in patients living with dementia. Clinicians working with older adults in residential care environments should be very familiar with at least one of these (e.g., the Physician Guidelines for the Screening, Evaluation, and Management of Alzheimer's Disease and Related Dementias; http://championsforhealth.org/alzheimers). Of note, recently the FDA approved the second-generation antipsychotic medication, pimavanserin (Nuplazid), for use with patients living with Parkinson's disease and psychosis. Pimavanserin, is the only antipsychotic to have FDA approval for use in patients with a form of dementia [20]. In general, the important steps when evaluating behavioral symptoms in an older adult living with dementia are:

1. Rule out underlying medical illness as the cause of the behavioral problems.
2. Identify and remove any environmental triggers.
3. Implement behavioral interventions.
4. Use psychiatric medications only when behavioral interventions fail or when the behaviors are so serious that imminent harm is likely to occur.

5. Combine pharmacological, behavioral, and psychological interventions to achieve potentially quicker, safer, and more long-lasting results.

– *B – Are there resident characteristics associated with bad outcomes and more frequent ED transfers from senior residential care environments?*

Residents of senior living communities, and especially NHs, may have complex comorbidities that often challenge the busy ED provider who is trying to differentiate between acute and chronic illness during a time-limited encounter. Likewise, the often chaotic ED environments can be difficult for any patient with a health crisis but are especially challenging for older adults living with a dementia illness. Many transfers from the NH to the ED are believed to be either unnecessary or preventable and may result in more harm than benefit. According to one study, 47 percent of all long-stay NH residents experienced at least one transfer to the ED over the course of a year. At the time of their first ED transfer, 36.4% of the participants were admitted to the hospital, whereas 63.1% of those who visited the ED were not. The median time to first ED visit for the participants with dementia was significantly higher than for the participants with no dementia [21]. Due to the high costs and poor quality of care involved in unnecessary transfers, they have become a target of policymakers and a focus of a Centers for Medicare and Medicaid Services demonstration project [22].

– *C – Nursing homes* versus *assisted living*

NHs have been the primary source of institutional care for older adults since the inception of Medicare and Medicaid in 1987 [23]; however, the combined impact of a growing number of older adults, a shortage of NH beds, the increasing costs of nursing care, the better health of new cohorts of older adults, and dissatisfaction with NH care have increased focus on other care settings [24]. Specifically, awareness has increased regarding the gap in the "continuum" of care between independent senior housing options (that cater to the older adult population with no functional impairments) and nursing facilities (that provide care to the chronically ill and disabled) [24]. As a result, CCRCs and larger NHs have broadened their range of care to bridge this gap, resulting in the stand-alone ALFs, which have increased dramatically since the 2000s. The original ALFs were modeled after Dutch residential settings and aimed to provide an "invisible support system" in a residential setting [25]. ALFs, however, are not subject to the same licensing restrictions and guidelines expressly encouraging aging in place [24]. Furthermore, although the ALF's professional organizations endorse providing a homelike environment, independence, autonomy, and privacy to their residents, facilities that do not subscribe to this philosophy are free to use the same term. In addition, the term ALF is not always used by facilities that do aspire to the type of environment described above [26].

Differences in the culture of the various residential care environment options available to seniors are evident from studies that compared their admissions thresholds. NHs were more likely than ALFs to admit impaired residents, both overall and

specific to those with activities of daily living (ADL) impairments. Within ALF facility types, smaller facilities consistently housed the most impaired residents, and traditional facilities consistently housed the least impaired. Adults with ADL, cognitive, and behavioral impairments are most prevalent in younger facilities (less than 5 years old) and those that are for-profit. Facilities with higher rates of resident impairment have more lenient admission policies, provide less privacy, and less resident control—all areas seemingly consistent with the realities of a more impaired population [27]. Given that newer NHs do not differ from traditional and newer model ALFs in the provision of social and recreational services (e.g., exercise, outside entertainment, groups), policy clarity (e.g., holding orientations and staff meetings, distributing newsletters) and resident control (e.g., conducting resident meetings, involving residents in plans regarding activities and room changes) may be indicative of improvements that have been made in the philosophy of NH care. Perhaps because of regulations or an evolution in response to consumer demand and the growth of ALFs, there may be increasingly blurred distinctions between NHs and ALFs [27]. Whether a community is for-profit or not-for-profit also plays a role in the culture and philosophy of the community. For-profit ALFs may face an inherent conflict between optimal resident care and financial constraints/pressures that might be less overt in a not-for-profit facility. In contrast, not-for-profit ALFs sometimes have charitable sources to subsidize residents who cannot afford to pay for their care [28].

The number of choices may make selecting the best option for residential care difficult. There are many guidance sources available for older adults who need help determining what option may be best. In many communities, for-profit businesses that specialize in helping older adults and/or their family members make these decisions now exist. If the decision to move to residential care is made near the end of an inpatient hospitalization, then a hospital social worker may be able to provide guidance. In addition, there are several not-for-profit organizations, such as the local chapter of an Alzheimer's Association, that are also able to help. Lastly, there are a growing number of reliable online sources of information, including information provided by the federal government and by a number of state and local governments, to aid in the decision-making process.

– *D – Impaired residents and nonverbal communication: Can agitation and incontinence be used as communication tools?*

The *need-driven dementia-compromised behavior model* conceptualizes problem behaviors as attempts to communicate unmet needs that, if responded to appropriately, will enhance the individual's overall quality of life [29]. An unmet need can trigger increased levels of frustration, which, in turn, may lead to further dissatisfaction, agitation, and eventually disruptive and dangerous behaviors. In fact, abuse in nursing facilities occurs bidirectionally. It is a "double-edged sword," with staff mistreatment of residents being the most visible edge. However, resident abuse of staff also occurs, but continues basically unnoticed as outsiders primarily focus on the quality of resident care [30].

Furthermore, incontinence is very common in nursing homes and affects approximately 40–75 percent of residents. It is often a major factor in decisions to institutionalize [11]. Incontinence is typically associated with shame and loss of self-esteem. Unfortunately, for restrained or severely debilitated residents, incontinence provides one of the few remaining possibilities for protest. Its most immediate impact is a significant workload increase for staff members which may lead to job dissatisfaction or burnout [31].

– *E – How do different cultural beliefs among various minority groups affect attitudes toward mental health disorders and access to treatments?*

The changing age profile of populations in all western countries means that dementia will become a more significant issue and demands for various supportive services will be greater in the future. A report regarding individuals living with dementia noted less use of services among individuals and their caregivers who belong to certain ethnic minorities when compared to members of other ethnic groups. The authors of this report argued that the needs of this subset of individuals may be unidentified, underrepresented, or unmet [32]. The reasons mentioned in the literature for these observed variations in levels of resource utilization include [33, 34]:

(a) Differences in prevalence rates between the ethnic groups
(b) Cultural deficiencies in the instruments used to assess cognitive function
(c) Differing cultural interpretation of the signs and symptoms of dementia
(d) Different age stratification found in minorities in various countries
(e) The stigma revolving around mental illnesses
(f) A lack of knowledge and understanding of available resources and services
(g) A general reluctance to use health and social resources and services which some members of ethnic minorities may perceive as culturally inappropriate, or even racist
(h) Language barriers, particularly when it comes to first-generation immigrants living with dementia

By 2050, it has been projected that approximately 40% of the older adult population will belong to a racial or ethnic minority [7]. The broad categories used by the US federal government to define ethnic minorities—African Americans, American Indian and Alaska Natives, Asian Americans, Pacific Islanders, and Hispanic Americans—do not capture the broad range of cultural differences that can play a role in defining illness and selecting treatment. Examples of groups in the USA with particular healthcare needs include Ethiopians, Haitians, Holocaust survivors of different nationalities, Hutterites, Laotians, Mexicans, Somalis, Russians, Vietnamese, and people from Eastern Europe and from countries in Central America. Examples of culturally based behaviors in various ethnic and cultural groups include: [1] Russian immigrants may neglect to obtain insurance because they are accustomed to the government's providing healthcare and other necessities by default; Afghans, Bosnians, and Somalis, may be suffering from overlooked posttraumatic stress

Table 11.1 Cultural differences regarding family members serving as caregivers [33, 35]

Ethnic or racial group	Caregiving as a family obligation	Possible reasons for not seeking services
Hispanic Americans	Yes	Stigma about mental illness Illness seen as punishment for past sins
Asian/Pacific Islanders Americans	Yes, mainly oldest son and wife, followed by rest of children if needed	Strong shame and stigma leading to frequent somatic presentations Symptoms seen as natural and untreatable consequence of aging
American Indians	Not typically	Poor services in native regions Symptoms seen as a normal process of aging Little stigma and shame from behavioral problems and confusion in older adults
African Americans	Yes, informal support from extended family, kin, and religious community	Lack of knowledge or awareness of resources Illness caused by various life stressors

disorder (PTSD) resulting from war, torture, or ethnic conflict [36]; and immigrants from Central America and Mexican-Americans may also be at risk for PTSD resulting from violence experienced in their home country, during their journey to the USA, or as a result of experiences associated with attempts to immigrate [37]. San Francisco General Hospital provides a model outlining how to address the range of ethnic minorities represented in their psychiatric inpatients [38]. The department offers different inpatient programs for Hispanic, Asian and Pacific Islander, African-American patients, as well as programs for women, HIV-positive patients, lesbian and gay patients, and forensic patients.

The *Cultural Influences on Mental Health* (CIMH) framework is a useful approach when characterizing cultural factors that develop in a relationship between the patient and the mental healthcare system. This model suggests that various cultural influences contribute to the etiology and development of mental illness and affect how one personally defines symptoms and illness. For example, cultural differences may contribute to the prevalence of mental disorders, influence beliefs about the causes of mental illness, and subsequently impact treatments and interventions [7]. The goal of describing the various cultural influences is not to stereotype groups— as groups are composed of unique individuals— rather, the goal is to sensitize practitioners of various disciplines to ethnocultural issues, values, and needs. Table 11.1 summarizes cultural differences regarding family members serving as caregivers in four different ethnic or cultural groups.

– *F – Do cultural competence trainings work?*

Cultural characteristics represent an integral aspect of all parts of life and play a major role in defining one's self-identity. The degree to which healthcare providers are culturally aware can shape the patient's ability to receive and apply information regarding their own healthcare, which consequently affects their overall health and health outcomes [39]. Educational programs that are sensitive to cultural diversity

have the potential to produce culturally responsive healthcare assessments that yield optimal healthcare interventions and practices. For example, the APA practice guideline for treatment of patients with Alzheimer's dementia recently highlighted several cultural characteristics that affect care including symptom presentation, familial acceptance of the behavioral disorder, caregiving style, and size of and support from social networks [7]. Cultural sensitivity trainings for providers have demonstrated increased open-mindedness and cultural awareness, improved understanding of multiculturalism, and enhanced communication quality with members of ethnic and racial minorities. A study on the effectiveness of cultural sensitivity training of foreign-trained medical graduate students found that those who received cultural sensitivity training were more open and resilient, had increased self-confidence and tolerance, were nonjudgmental, were able to deal with ambiguity, and were capable of better understanding others [39]. Those who were trained also exhibited improved skills in assessing verbal and nonverbal cues communicated to them by people who were from different backgrounds than themselves [39].

– *G – Work environment hierarchy in nursing homes: Is a change needed?*

Just as in homes and communities, organizations create their own unique and dynamic cultural environments. It is not uncommon for residential care settings to have tension and conflict between staff members, which may have a significant impact on the residents and the care provided there. For example, in the USA, some NHs struggle with tension between different clinical professions and hierarchies. Nursing aides or certified nursing assistants (CNAs) typically tend to the basic bodily needs of residents, including elimination and incontinence care. Given their frequent contact with blood, feces, sputum, vomit, and urine, aides are very much at risk of becoming ostracized as "polluted people" or "dirty workers," whose sole job is to clean up a mess. Unlike aides, professional nurses in nursing homes are, for the most part, able to evade elimination care, which sometimes creates conflict between CNAs and RNs. Nursing assistants, it seems, are reluctant to accept the postulate that a nursing license exempts its bearer from elimination care or that their lack of license exempts them from being more useful to the residents [38]. Spending consistent time with residents helps CNAs become familiar with residents' patterns of health and behavior and their likes and dislikes. Familiarity with their residents promotes the development of relationships, as well as the CNAs' expertise in making day-to-day care decisions on the residents' behalf. Further, research shows second-career CNAs tend to have altruistic intentions and are more influenced by relationships and the desire to make a difference than by money [40]. More so, they expressed their values and ideals through their work and sought to transform nursing home care. Yet, difficulty retaining these long-term care workers continues to plague nursing homes, as turnover rates approach 100% [41]. Researchers have documented that these CNAs' decisions to leave their jobs were influenced less by hard work and low pay and more by feeling devalued by administration and other staff [40].

The work environment hierarchy may have played a role in the poor response that J received when he was asked to share his approach with other staff members at Mr. X's NH. In a naturalistic survey, one CNA described their experience in the workplace as:

> Transitioning between two worlds: In one world, the institution provides care to numerous frail older adults, while meeting state and federal regulations. In this world, CNAs are replaceable workers. In the other world, the home offers a sense of community and a home-like environment where the residents' individual needs and preferences are attended to. In this world, CNAs are considered valued members of the team and the community. [42]

Successful nursing home communities have demonstrated that they value CNAs by seeking their input in resident care planning, providing mentoring activities, and respecting their work. Important, then, is the adoption of policies and practices that create an atmosphere of valuing and appreciating CNAs' contributions [43]. Whether it is tension between nurses and nursing assistants or conflict between other groups of staff or individuals, these conflicts impact the culture of the residential care environment and need to be identified and resolved to optimize the resident's experience.

– *H – Sexual behaviors in residential care environments. Given the spectrum of possible causes, what is the optimal outcome?*

Sexual expressions remain important for a significant proportion of older people. Despite this, within healthcare systems, the sexual needs of the older adults are often unrecognized and unmet. Frequently, this occurs as a result of negative attitudes and beliefs surrounding sexuality, sex, and sexual desires, especially in older adults [5]. A majority of older adults, even those residing in long-term care environments, maintain some level of sexual interest, albeit at decreased levels. Future cohorts of older adults are expected to have even greater sustained interest in sex, as well as higher frequency of participation in sexual acts, as generational acceptance and perception that sexuality is normal for older individuals increase [44]. Evidence suggests, however, that sexual desire is mediated not only by age but also by psychosocial factors including partner availability, frequency of contact, and generational perceptions of the appropriateness of sexual activity in later life [45], as well as biological factors, including the presence of chronic diseases and the medications used to treat them [46]. For residents living in long-term care settings such as assisted living, these factors are likely to be highly relevant.

Historically, the culture of most residential care environments for older adults has not supported the sexual needs of the residents. Physical aspects of life in a residential care environment are one of the most common and significant barriers to sexual intimacy, such as living in a shared room with only a curtain between the beds for privacy. The cultural beliefs and attitudes of personal and professional caregivers, however, are another common obstacle for sexual expression. Studies have shown that nursing home staff members' attitudes toward sexual behaviors in older adults –which are primarily negative– present another barrier to residents fulfilling their sexual needs [47]. Such attitudes often lead clinical and support staff, including housekeeping and

food service team members, and members of the management team to perceive any attempt at sexual expression as inappropriate, even by residents without cognitive impairment. Preferred forms of sexual expression vary widely. Sexuality and intimacy are manifested in various ways, including intercourse, but findings overwhelmingly reveal that intimate touch, hand holding, and other less physically intense expressions are common and valued just as significantly as younger individuals might enjoy more vigorous physical expressions of sexuality [48].

Assisted living policies regarding sexuality were found to be sometimes informal and vague. For example, some assisted living directors instruct their staff to leave quietly when they observe sexual activity in residents' apartments. Facilities' responses to sex and intimacy are context related. Assisted living settings' responses to sex and intimacy are couched in the social context of the situation. Directors and staff rely on the family members' and powers' of attorney wishes and directives. They can be permissive if the family is supportive of relationships but can reinforce limit setting if the family is not accepting the behaviors. If an assisted living setting has a low census of patients, policies may become more flexible. Problematic sexual behavior may be discouraged but impulsive patients will not be banned [48]. Advance directives are generally used to give guidance concerning medical care, not sexual relationships. As directives become more widely used, however, they may also be used to specify other aspects of care the patient wishes to receive when incompetent, including sexual behavior. In fact, "some individuals may feel so strongly about loyalty to a spouse or religious belief that they may include directives concerning future sexual relationships" [49]. Cultural training around the healthy expression of sexual behaviors in older adults may be needed to ensure that older adults who want to remain sexually active receive proper acceptance, education, understanding, and support, even after moving to a residential care community.

– *I – LGBT discrimination exists in residential care environments and nursing homes*

According to the National Gay and Lesbian Task Force, there are currently between 1.4 and 3.8 million lesbian, gay, bisexual, and transgender (LGBT) Americans over the age of 65 [50]. They remain particularly at risk of both homophobia and heterosexism. Homophobia is defined as the unreasonable hatred, prejudice, and fear of LGB people. Transphobia is the term to describe hatred, prejudice, and fear of transgender individuals. Heterosexism and cisgender status function as default assumptions; it is a bias where the heterosexuality and cisgender of most people are presumed. Institutional heterosexism relies on the assumption of heterosexuality as the norm when health services are provided resulting in the needs of LGBT people being neglected [51]. *The LGBT Cultural Competency Project* is an example of a collaborative initiative between multiple partnerships with a primary goal of providing education and awareness of the unique needs and concerns of LGBT older adults who are aging into long-term care communities [51]. Many LGBT older adults are concerned about entering nursing homes due to fears that they will be forced into the closet to avoid being shunned by other nursing home

residents for being openly lesbian, gay, bisexual, or transgender. Others fear mistreatment by administrative staff, care staff, and peers [52]. In fact, "invisible" is a recurring description of older LGBT individuals. Although "passing" is used as a survival tactic to protect against discrimination, the trauma for those who have lived their lives openly and honestly but find themselves going back into hiding when "they become ill, vulnerable and dependent on others" should not be minimized [53]. Transgender persons are at particular risk of avoiding institutions and situations where they would be forced to rely on assistance from insensitive and transphobic providers, for example, in vulnerable situations such as bathing [53].

Until June 26, 2015, when the US Supreme Court legalized same-sex marriage in all fifty states, the absence of federal recognition of same-sex unions made same-sex couples ineligible to receive financial and other benefits offered to couples in opposite-sex marriages. As LGBT people age and become more dependent on federal benefits, such as Social Security, Medicare, and Medicaid (none of which were previously extended to same-sex partners), and become more enmeshed in healthcare systems that do not grant their partners the same rights as legal spouses, they experience the effects of a lifetime of inequality. These effects can follow a lesbian or gay person into the nursing home setting [54]. Furthermore, for a long time, most retirement communities in the US were faith-based; this meant they could discriminate without bounds because of their exemption from most nondiscrimination statutes. As an alternative to faith-based homes, several retirement communities catering to the LGBT community have now opened around the country. The most well-known of these is called RainbowVision, the first US retirement village designed specifically for gay men and lesbians in Santa Fe, New Mexico [52]. Similar communities now exist in a number of major American cities.

Some nursing homes, including those that do not specifically cater to the LGBT community, have endorsed the *HEALE* curriculum [53]. The *HEALE* curriculum sets a standard for best practices in nursing management and for LGBT cultural competency in geriatric education. The nurses' *HEALE* training has significantly increased knowledge and, as a result, nurses' confidence in providing culturally sensitive care to older LGBT individuals [53]. However, a nationally representative mail-in survey of nursing home social service directors revealed that LGBT cultural trainings are still not the norm. More than 75% of responders reported not receiving any training during the previous 5 years [55]. If the nursing home where Mr. X was living had asked about his sexual orientation and provided him with appropriate options for the expression of his sexuality, it may have reduced the likelihood of inappropriate behavior with J.

– *- J – Person-centered care: What works?*

In the early 1980s, the National Citizens' Coalition for Nursing Home Reform conducted focus groups to learn directly from the nursing home residents their definition of quality. Subsequently, the Institute of Medicine committee on nursing regulation published *Improving the Quality of Care in Nursing Homes*. This was followed by a sweeping set of nursing home reforms, known as the Nursing Home

Table 11.2 The principles of patient-centered care

Patient-centered care principles	Description and examples
1. Resident direction Care and all resident related activities are directed as much as possible by the resident	Residents are offered choices and encouraged to make their own decisions, such as what to wear, when to go to bed, and what time to wake up
2. Homelike atmosphere Practices and structures are designed to be less institutional and more homelike	Small "households" of 10 to 15 residents in the organizational unit. Meals are prepared on the units, and residents have access to refrigerators for snacks
3. Close relationships Relationships between residents, family members, staff, and the community are close	For example, the same group of nurse aides consistently care for a resident (a practice known as *consistent assignment*), in order to increase mutual familiarity and caring
4. Staff empowerment Work is organized to support and empower all staff to respond to residents' needs and desires	Teamwork is encouraged, and additional staff training is provided to enhance efficiency and effectiveness
5. Collaborative decision-making Management enables collaborative and decentralized decision-making	Flattening of the typical nursing home hierarchy and participatory management systems is encouraged. Aides should be given some decision-making authority
6. Quality improvement processes	Systematic quality improvements that are comprehensive and measurement-based should exist

Reform Act, which was incorporated into the Omnibus Budget Reconciliation Act of 1987. The law made nursing homes the only sector of the entire healthcare industry with an explicit statutory requirement for providing what is now called "person-centered care" [8]. This *culture change movement* is a broad-based effort to transform nursing homes from impersonal healthcare institutions into true person-centered environments offering long-term care services. The *culture change movement* represents a fundamental shift in thinking about nursing homes. Facilities are viewed not as healthcare institutions but as person-centered homes offering long-term care services. Table 11.2 summarizes the principles of person-centered care which include not only resident care practices, such as elimination of physical restraints but also organizational and human resource practices and the design of the physical environment.

The culture change to patient-centered care should be recognized as far more than offering amenities or making superficial changes. Rather, it should be treated as an ongoing process affecting overall performance and leading to specific, measurable outcomes. For example, older adults may be well cared for in terms of their healthcare, hygiene, nutritional needs, and housekeeping (quality of care) but still be unhappy. Some of the possible reasons for this unhappiness include consuming unappealing food, being required to bathe in the morning when they prefer an evening shower, awakening to vacuuming in the middle of the night because that is when there is the least amount of foot traffic, and feeling lonely for companionship [56]. Making an effort to keep shower rooms warm can make bathing a more pleasurable experience for residents, reduce staff stress, save time, and avoid agitation [8].

Material objects can be used to help people with dementia maintain connections to past social identities and roles and provide a sense of comfort and security. Handbags, for example, imbued with social and personal meaning, can serve many different functions for women living in care homes. First, the tangibility and accessibility of a handbag can itself provide reassurance, particularly when the owner feels vulnerable. The act of rummaging or sorting through a handbag also provides women in care homes with a "distraction"—a means of looking busy or purposeful when sitting alone in a public space, disguising a sense of discomfort. More so, handbags also provide a "prop" for managing the lack of privacy in care home settings [57]. In the same spirit of using physical materials, a growing body of evidence is showing that dolls provide comfort and companionship for some residents with advanced Alzheimer's disease in their care homes [58]. Felt dolls provide sensory stimulation and seem to promote purposeful activity. Dolls were noted to promote positive changes in behavior, reducing aggression and agitation. They also increase interactions between staff and residents as their interactions expand to discussions and activities relating to the doll, such as folding the doll's clothes together [58]. When integrating the use of a doll into the care of a patient, it is recommended that family members and friends of the patient be educated about the value and purpose of the doll.

Despite widespread recognition of the *culture change movement*, the discovery of deep and enduring cultural change is relatively rare. Several aspects of the nursing home industry, including its workforce, regulation, and reimbursement, have conspired to limit the initiation of culture change practices [8]. The Commonwealth Fund's 2007 National Survey of Nursing Homes found that only 5% of nursing directors said that their facilities completely met the description of a nursing home transformed through *culture change*. Only 10% reported that they had initiated at least seven or more *culture change* practices. Altogether, about one-third reported adoption of some *culture change* practices, and another third said that they were planning to follow suit. But the remaining 40% of the respondents said that they were neither practicing nor planning to commence *culture change* [8].

On the other hand, Green House (GH) NH models, which strive to fully express the tenets of culture change, are gaining in popularity and have elicited great interest among policy, provider, and research stakeholders, in large part because they offer a true alternative to traditional models of nursing home care by focusing on person-centered care and deinstitutionalizing the NH. Between 2011 and 2014, the Robert Wood Johnson Foundation funded an independent evaluation of Green House NHs by four project teams, which were organized under the umbrella of The Research Initiative Valuing Eldercare (THRIVE). The collaborative interrelated research projects of these teams examined GH care processes and outcomes. THRIVE concluded that implementation of the GH model is inconsistent in different homes, sometimes differing from design [59]. Among many recommendations, THRIVE research established the importance of communication and collaboration between and among direct care staff and medical care providers to effect good-quality care [59].

In GH homes, *consistent assignment* of a universal worker who directs care staff, and small homes built around a central living area allow familiarity with residents

and provide opportunities for frequent interactions among staff. If used in an optima manner, increased multidisciplinary collaboration might lead to early identification and intervention in response to a resident's change of medical condition, a vital step in quality care. Some GH homes were found to take advantage of these opportunities to improve quality; others did not [59]. Consequently, GH leadership and others promoting *culture change* to improve care should identify and overcome barriers to communication and collaboration. The THRIVE studies suggest that scheduling physician, nurse, and other professional staff visits should be more purposeful, and congregate areas should be used to promote interaction [59].

Conclusion and Recommendations

Be it in traditional NHs, in progressive person-centered nursing homes, or assisted living communities, cultural challenges in care provision are common. An important role of the geriatric psychiatrist on both clinical and institutional levels is to help address these challenges. Practicing cultural competence in long-term facilities requires education about and sensitivity toward different cultural identities including race, gender identity, and sexual orientations. In addition, awareness of the impact of staff hierarchies in residential care environments, implementation of patient-centered approaches, and the removal of common barriers to their adoption are also essential. We conclude with a number of recommendations to help clinicians navigate the potentially challenging yet rewarding task of integrating the cultural identity of an older adult with the culture of the residential care environment:

(a) Be mindful of the location (urban vs rural) and culture, e.g., (traditional vs person-centered) of the residential care environment and the available services and prescribing trends.
(b) Obtain a good history of the nursing home resident and their behavior, which may help avoid costly and unnecessary trips to the ED that are especially difficult for many older adults, especially those living with dementia.
(c) Use your knowledge of the patient and the complexity of their comorbidities to guide the choice of placement in an ALF vs NH. Other factors to be taken into consideration include the size and age of the institutions, their philosophy, and financial sustainability.
(d) Keep an inquisitive mind about interpreting reported disruptive behaviors like agitation or incontinence. Sometimes these behaviors are inspired by unmet needs or unaddressed frustrations.
(e) Be mindful of various religious or cultural beliefs, family traditions and involvement, possible sources of shame or stigma, and culturally influenced interpretations of symptoms— any and all of which can play a major role in explaining the medical diagnoses, prescribed treatments, and recommended supportive services and in establishing reciprocally supportive and rewarding relationships with family members and friends of the resident.
(f) Attend a cultural competency training. These have shown efficacy in increasing humility and tolerance but also reducing judgments and frustrations.

Psychiatrists aiming to ensure a culturally sensitive practice in their facility ought to implement them as part of their pre-employment trainings.

(g) Empower nursing assistants, and recognizing that these team members are a valuable, yet often under-recognized, part of the treatment framework. Ensuring they are heard and given room for creative interventions can play an important role in person-centered care culture.

(h) Remember that sexual behaviors in a nursing home are common and not necessarily a sign of disinhibition, or malintent. A discussion incorporating family preferences, home philosophy, and the residents' values and wishes should guide approaches toward the sexual expression of residents, especially those with a diagnosis of dementia.

(i) Arrange LGBT competency trainings for nursing home staff members to promote culturally sensitive practices and avoid institutional heterosexism and cisgenerism, which have been shown to directly impact the mental health of residents.

(j) Promote a *person-centered* approach in NHs and proprietary residential care environments for older adults. To do this, the psychiatrist must be well-versed in non-pharmacological interventions and take initiative with all parties involved to ensure effective communication and the delivery of holistic care.

Summary of High Yield Points

- In the USA, 4.2% of individuals 65 years old and older live in nursing homes [1], and the need continues to grow as the population of older adults increases.
- There are numerous residential care options for older adults other than nursing homes including independent living, assisted living, subacute care hospitals, rehabilitative facilities, retirement communities, and continuing care retirement communities.
- Psychiatric disorders in older adults living in residential care communities are common. The most common diagnosis is dementia, with prevalence rates of 50–75% [9]. Combining pharmacological, behavioral, and psychological interventions will achieve potentially quicker, safer, and more long-lasting results.
- Many transfers from nursing homes to the emergency departments are believed to be either unnecessary or preventable and may result in more harm than benefit.
- Agitation, incontinence, and aggressive or disruptive behaviors may be forms of communication by impaired and/or nonverbal residents.
- Individuals living with dementia who belong to certain ethnic minorities do not use services to the same degree as members of other ethnic groups. This suggests that the needs of this subset of individuals may be unidentified, underrepresented, or unmet [32].
- Lesbian, gay, bisexual, and transgender individuals have historically avoided proprietary residential care environments due to fears about mistreatment by administrative staff, care staff, and peers [51]. The *HEALE* curriculum is a six-hour LGBTQ cultural competency continuing education training for nurses and heathcare professionals and is provided to nurses and social workers for free care.

- After a series of publications, policies, and laws passed in the 1980s, nursing homes are the only sector of the entire healthcare industry with an explicit statutory requirement for providing what is now called *person-centered care* [8]. However, despite widespread recognition of the *culture change movement*, the transition to deep and enduring cultural change in proprietary residential care environments, including nursing homes, has been relatively rare.
- The geriatric psychiatrist has the important role of ensuring comprehensive and individualized care, addressing clinical and organizational cultural issues, and promoting advocacy and policy recommendations.

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