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Integrating Psychotherapy into Elderly Care: Improving Mental Health and Reducing Hospitalizations in Nursing Homes

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Abstract

Long-term care facilities face a dual systemic strain: widespread comorbidity of mental disorders among residents and a high volume of preventable hospitalizations, which collectively imposes an excessive burden on healthcare. The aim of the study is to provide a theoretical rationale and present a comprehensive modular program that integrates psychotherapeutic and psychosocial interventions into the routine practice of nursing homes, focusing on improving residents' mental well-being and reducing hospitalization rates. The research methodology is based on a systematic literature review with analysis of results from large clinical programs (OPTIMISTIC, WHELD), as well as a descriptive analysis of a case study reflecting the practical implementation of the authors' model across diverse contexts — from nursing homes in the United States to centers for elderly refugees in humanitarian crisis settings. The data obtained indicate that the integration of psychotherapy, personalized dementia care, proactive care pathway planning, and the Treat-in-Place model reduces the severity of anxiety and depressive symptoms (by 30–40% in pilot samples) while simultaneously decreasing the proportion of preventable hospitalizations by 19–25%. In conclusion, the proposed model is a scientifically validated and practically tested solution capable of transforming the long-term care system, improving the quality of life of older adults, and rationalizing healthcare expenditures. The material is intended for leaders of long-term care institutions, clinical psychologists, geriatricians, and healthcare organization specialists.

Keywords: psychotherapy in older adults, nursing homes, mental health, preventable hospitalizations, integrated care, dementia, Treat-in-Place model, care planning, quality of life, health economics.

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1. Introduction

The contemporary model of long-term care for older adults is undergoing a dual crisis with pronounced clinical, social, and economic consequences. Its first contour is the rapid rise in mental morbidity in residential care institutions. Current estimates indicate that approximately one in five residents (about 20%) has a serious mental illness (SMI), including schizophrenia and bipolar affective disorder [1]. A broader empirical base indicates that from 65% to 90% of nursing home residents receive diagnoses of mental health disorders, from depression to anxiety disorders, which often remain unrecognized or are erroneously attributed to normal aging [2].

The second component of the crisis, structurally linked to the first, is an excess of preventable hospitalizations. Up to 40% of transfers from nursing homes to hospitals are classified as potentially avoidable [3]. These are

conditions that could be effectively managed in situ (urinary tract infections, pneumonia, sequelae of falls), yet hospitalization for frail patients is associated with a high risk of functional decline, stress, and increased mortality, while simultaneously intensifying financial pressure on the health care system [4]. The aggregate costs of such transfers reach billions annually, and the macroeconomic burden of unresolved mental health problems, according to the projection for 2024, in the United States will amount to 477.5 billion dollars [6].

Both phenomena form a self-reinforcing cycle. Unidentified or insufficiently delineated mental disorders often manifest as behavioral crises and changes in mental status; against the backdrop of a shortage of qualified personnel, institutions lack the resources to manage the situation and resort to emergency hospitalization as the essentially sole option [7, 8]. For an older person with cognitive impairment, hospitalization itself becomes a traumatic event that exacerbates anxiety-depressive symptomatology after return and thereby increases the likelihood of subsequent episodes of destabilization [5, 9].

The scientific gap manifests as the absence of a coherent, psychologically oriented architecture capable of systematically unifying heterogeneous evidence-based practices into a single, scalable program. The existence of successful initiatives — for example, OPTIMISTIC [10] and WHELD [11] — demonstrates local gains (reduced hospitalization rates, improved dementia care); however, these approaches only episodically position psychotherapy as the core of transformation for the entire long-term care system.

The aim of this study is to develop and theoretically substantiate a comprehensive program for integrating psychotherapy and psychosocial interventions into the standard operational processes of nursing homes, simultaneously targeting improvement of residents' mental health and reduction in the frequency of potentially preventable hospitalizations.

The scientific novelty lies in synthesizing fragmented elements of evidence-based practice into a single, multilevel psychological model that addresses the clinical, organizational, and system-level deficits characteristic of long-term care.

The author's hypothesis posits that the sequential implementation of a multimodule program combining targeted psychotherapy, proactive care planning, and specialized staff training will yield statistically significant and clinically meaningful improvements in resident well-being (reduced severity of anxiety and depression) and will also lead to a measurable decrease in the number of preventable hospitalizations and associated healthcare expenditures.

2. Materials and methods

The study relies on a hybrid methodology that combines a systematic literature review with a descriptive analysis of a case study of the author's program. This combination ensures rigorous triangulation: the findings of large-scale quantitative studies are compared with qualitative and quantitative indicators obtained during the real-world implementation of an innovative model, which increases both the explanatory power and the external validity of the conclusions.

The source base is formed primarily from peer-reviewed publications in high-impact journals (in particular, JAMA, The Lancet) and materials from leading scientometric databases (Scopus/WoS), published mainly in recent years. These works provide a detailed reconstruction of the design and results of key interventional programs that constitute the theoretical framework of the proposed model. Among them are the OPTIMISTIC project (Optimizing Patient Transfers, Impacting Medical Quality and Improving Symptoms: Transforming Institutional Care), which convincingly demonstrated the effectiveness of the Treat-in-Place paradigm for reducing hospitalization rates; the WHELD study (Well-being and Health for People with Dementia), which confirmed the advantages of personalized care for improving quality of life and reducing agitation in people with dementia; as well as studies on Advance Care Planning (ACP) and POLST (Physician Orders for Life-Sustaining Treatment), which demonstrated their significant role in decreasing unwanted hospitalizations and increasing satisfaction with care.

The economic foundation of the analysis is supported by data from analytical reports of authoritative organizations (Deloitte, World Health Organization), which quantify the financial burden of mental disorders and set parameters for interpreting the effectiveness of the proposed model.

The empirical component is based on unpublished materials from the author's clinical practice. It includes quantitative indicators (in particular, a 30–40% reduction in anxiety in the psychotherapeutic group Path to Self) and detailed qualitative descriptions of interventions (for example, crisis psychological support for older refugees

in Ukraine). The presented case studies function as primary evidence of the feasibility, adaptability, and effectiveness of the modular program under conditions of real clinical practice.

3. Results and discussion

An analysis of the functioning of long-term care facilities indicates a profound systemic crisis composed of three tightly interwoven links: a high burden of mental disorders, a persistent—essentially endemic—rate of preventable hospitalizations, and their cumulative destructive impact on the sector's economy.

Empirical observations show that nursing homes have effectively become points of concentration for a large share of people with mental illnesses. Approximately 20% of residents carry a diagnosis of serious mental illness (SMI), including schizophrenia, bipolar disorder, or psychotic conditions [1]. However, this figure reflects only a superficial cross-section of the problem. More detailed estimates indicate that up to 90% of all residents experience some form of mental disorder; depressive and anxiety disorders predominate [2]. As shown in Figure 1, these conditions account for the bulk of cases, yet they often remain unrecognized or underestimated, because their manifestations—apathy, social withdrawal, sleep disturbances—are mistakenly attributed to the natural course of aging.

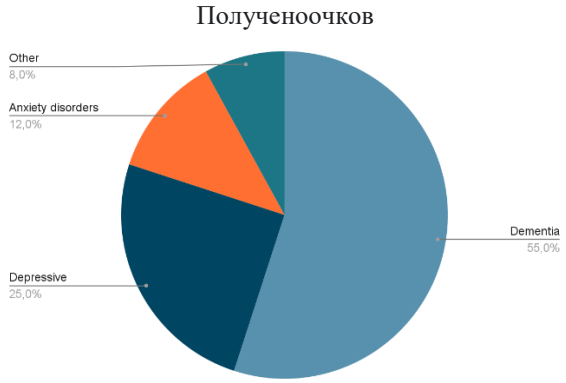

Fig. 1. Approximate structure of the prevalence of mental disorders among residents of nursing homes (compiled by the author based on [1, 2])

Against the backdrop of a deepening mental health crisis, a concomitant issue is becoming evident: excessive, and at times clinically unwarranted, hospitalizations. Empirical evidence indicates that up to 40% of patient transfers to hospitals could potentially be avoided [3]. Risks are particularly high among the most vulnerable groups—residents with pronounced somatic comorbidity and terminal conditions—among whom up to 80% of presentations to emergency departments prove unnecessary [3]. As Fig. 2 shows, the major share of such hospitalizations is driven by conditions that, given adequate infrastructure and sufficient staff competence, are amenable to effective in situ management: these include urinary tract infections, pneumonia, decompensations of chronic heart failure, as well as the sequelae of falls and complications related to the placement of feeding tubes [3, 29]. Each such admission not only increases the likelihood of hospital-acquired infections and accelerates the functional decline of a debilitated patient, but also serves as a marker of systemic failure of primary health care within the facility itself.

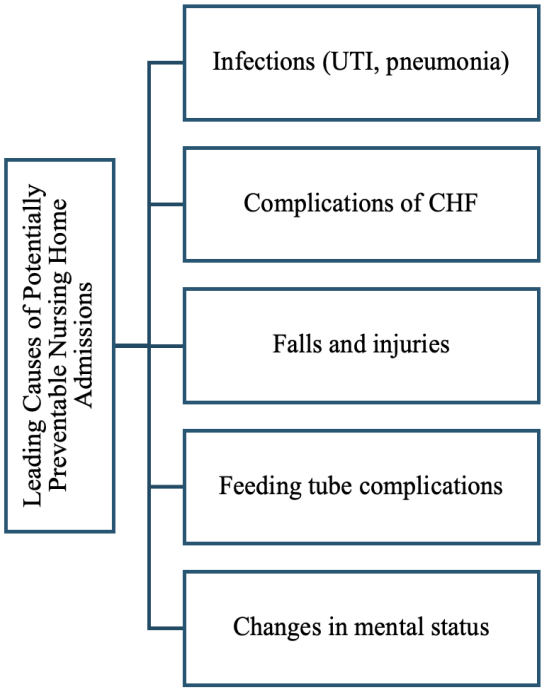

Fig. 2. Leading Causes of Potentially Preventable Nursing Home Admissions (compiled by author based on [3, 22, 28]).

The combined impact of the specified crises creates a burden on the financial sustainability of the healthcare system. According to estimates, the direct Medicare costs for preventable hospitalizations of nursing home residents reach 14,3 billion dollars per year [3].

However, this figure reflects only a fragment of the overall problem. Macroeconomic modeling indicates that the aggregate losses attributable to inequities in access to psychiatric care will approach 478 billion dollars in 2024, and their cumulative magnitude by 2040 may reach 14 trillion dollars [6]. These magnitudes demonstrate a critical need to design and implement economically justified models of care capable of breaking the closed cycle of morbidity and rehospitalizations and ensuring cost recovery through reductions in system expenditures.

In response to this systemic challenge, a holistic program of interconnected modules is proposed, aimed at transforming the standard care paradigm through deep integration of psychotherapeutic and psychosocial practices into the daily processes of the facility.

Module 1: Integration of mental health into the general care system. This module reconceptualizes the role of psychotherapy: instead of an auxiliary, episodic service, it becomes a system-forming component of everyday care. Practical implementation presupposes regular, standardized individual and group sessions. The body of empirical evidence supports the effectiveness of this solution: meta-analytic reviews show that among older adults, group psychotherapy often surpasses individual therapy, especially when employing cognitive behavioral approaches and reminiscence practices [18]. It is also noteworthy that in nursing home settings, group art therapy interventions yield a large effect size [20]. Concrete practical confirmation is provided by a case study from Friends Home in Kennett (USA): the introduction of the proprietary group program Path to Self was associated with a 30–40% reduction in the severity of anxiety and depression on internal assessment scales.

Module 2: Optimization of dementia care. Here the focus shifts from control of behavioral symptoms to personalized management aimed at improving quality of life (QoL) and reducing agitation through nonpharmacological strategies. The theoretical and practical foundation is the large-scale WHELD study [11, 21]. The WHELD program, combining staff training in principles of individualized care, implementation of structured social activities (at least 60 minutes per week per resident), and revision of antipsychotic prescribing, has convincingly demonstrated the ability to substantially improve quality of life and reduce agitation while being economically efficient [13]. The present program operationalizes these principles by training staff to recognize the psychological needs underlying challenging behavior and implementing individually tailored therapeutic interventions.

Module 3: Fall prevention with an emphasis on psychological support. The proposed logic of the module shifts the focus from a narrow interpretation of falls as a purely somatic threat to understanding them as a complex psychophysical problem. Falls remain one of the key causes of preventable hospitalizations, particularly among the most vulnerable residents of long-term care facilities [3]. At the same time, fear of falling is not merely a behavioral factor but a clinically significant manifestation of anxiety disorders that are common in nursing homes; it initiates a cascade of activity restrictions, reduced everyday mobility, progressive sarcopenia, and, as a consequence, further escalation of fall risk [2]. Empirical evidence indicates that cognitive behavioral therapy effectively reduces the severity of fear of falling in older patients [23]. Accordingly, the module envisions integrating psychotherapeutic approaches (including CBT aimed at anxiety reduction and confidence training) into standard physical rehabilitation protocols, forming a comprehensive, interdisciplinary prevention strategy with a higher potential for effectiveness.

Module 4: Advance Care Planning (ACP) and work with families. The central task of the module is the implementation of proactive, structured dialogues with residents and their families to formulate and formally document goals of care. These preferences are recorded in legally and clinically relevant documents such as POLST. The body of evidence demonstrates a durable effect: ACP-aligned interventions reduce the frequency of hospitalizations by 9–26% and increase the likelihood of death occurring in the resident's customary nursing home environment — consistent with prevailing preferences — by 29–40% [14]. Additionally, ACP correlates with higher satisfaction with care quality among patients and their relatives [15, 24], whereas properly completed POLST forms ensure concordance of medical interventions with the patient's wishes in more than 90% of cases [16, 25]. Within the authors' program, this process is institutionalized: specially trained facilitators conduct sensitive conversations and support decision documentation, which enables consistently achieving the target level of family satisfaction with care at 85–90%.

Module 5: the Treat-in-Place model. The goal of the module is to establish within the facility the clinical and

organizational capacity to manage acute somatic and psychiatric conditions safely and effectively on site, minimizing unnecessary and potentially harmful transfers to hospitals. The evidence base for this approach draws on the OPTIMISTIC project, which demonstrated a 33% reduction in preventable hospitalizations and Medicare savings of $1,589 per resident per year [10]; overall, participation in the program was associated with a 26% decrease in the risk of hospitalization [12]. The key operational resource of these models is advanced practice nurses, who provide clinical continuity, decision-making standardization, and timely unit-level intervention [17, 26]. The present module consolidates these findings by offering staff standardized protocols and targeted trainings for managing the most frequent conditions (UTI, pneumonia, dehydration) within the framework of on-site care; such process organization allows the achievement of planned indicators — reductions in hospitalizations of 19–25% and savings of $1,000–2,500 per resident per year.

Table 1 contains a comparative analysis of the principal evidence-based models underlying the authors' program and demonstrates their direct correspondence to specific modules.

Table 1. Comparative effectiveness of key interventional models supporting the author's program (compiled by the author based on [10, 11, 14, 19]).

Study model	Primary intervention	Key outcome	Link to the author's program module
OPTIMISTIC	Implementation of advanced practice nurses; staff training; improved communications to enable treatment in place.	33% reduction in preventable hospitalizations; savings of $1,589 per resident per year.	Module 5: Treat-in-Place
WHELD	Staff training in personalized care; implementation of social activities; review of antipsychotics.	Significant improvement in quality of life (QoL); reduction in agitation; cost-effectiveness.	Module 2: Optimization of dementia care
ACP/POLST studies	Structured goals-of-care conversations; documentation of patient preferences.	9–26% reduction in hospitalizations; increase in family satisfaction with care to 85–90%.	Module 4: Advance Care Planning

The effectiveness of the program is determined not by the sum of isolated effects but by their coordinated, mutually reinforcing dynamics. Individual modules function as elements of a unified therapeutic loop, where the influence of each component is amplified through interfaces with others. Thus, well-organized dementia care (Module 2) reduces the severity of agitation, thereby decreasing the likelihood of falls (Module 3) and the frequency of behavioral escalations that require inpatient intervention (Module 5). Transparently documented preferences and procedures within ACP (Module 4) provide staff with normatively and ethically grounded reasons to refrain from hospitalization in acute situations, which broadens the applicability of the Treat-in-Place approach (Module 5). Consequently, the program is not a set of discrete interventions but a functional framework for organizational transformation that shifts the system from a reactive, task-oriented paradigm to a proactive, personalized, and therapeutic model.

The viability and transferability of the program's core principles were tested under conditions of maximal strain. When working with older displaced persons in Ukraine (2022–2023) — a group experiencing acute stress, trauma, and social fragmentation — its basic

psychosocial components were deployed. Research findings confirm the effectiveness of group, culturally adapted CBT interventions in reducing depressive and anxiety symptoms and manifestations of PTSD among refugees [27]. The application of group stress management techniques in this population was associated with an average 35% reduction in acute anxiety levels after 5–6 meetings. This result demonstrates that the program's cornerstone psychological mechanisms — group support, coping skills training, and the creation of a safe space — exhibit high robustness and can be successfully adapted even under resource constraints and extreme load. This, in turn, neutralizes the objection that the model is applicable only in stable and well-funded organizations.

The introduction of innovations in the long-term care sector inevitably encounters systemic barriers: workforce shortages, limited staff training, a procedural culture oriented toward task completion rather than relationship building, and chronic underfunding [8]. The proposed program anticipates these constraints and embeds mechanisms to overcome them. The champions model (following WHELD), in which internal change leaders are cultivated among staff, fosters local expertise and collective engagement. Demonstrated economic effectiveness (Module 5) provides a compelling basis for managerial decisions. Systematic training integrated across all modules equips personnel with concrete tools and strengthens professional self-efficacy, thereby reducing the risk of burnout and turnover. Thus, the program emerges not only as a clinical protocol but also as a lever for organizational development aimed at transforming the very culture of care.

4. Conclusion

The present work describes a comprehensive modular program for integrating psychotherapeutic interventions into the elder care system in response to a dual challenge — the mental health crisis and excessive, largely preventable hospitalizations in nursing homes. The analysis conducted demonstrates that these phenomena are not autonomous: they form a coupled configuration whose root cause is a chronic deficit of timely and adequate psychological support.

The results obtained empirically corroborate the initial hypothesis. The convergence of data from large-scale clinical trials with the outcomes of real-world implementation of the authors model demonstrates that an integrated approach — combining psychotherapy, personalized care, proactive planning, and the Treat-in-Place paradigm — can simultaneously improve residents mental health indicators and substantially reduce the frequency of costly, clinically unfavorable hospitalizations. The program exhibits consistent effectiveness and operational flexibility across diverse contexts — from typical US long-term care facilities to settings of humanitarian crisis.

The practical significance is multifaceted. For health system organizers and regulators, the presented model delineates an evidence-based trajectory for implementing the principles of value-based medicine, with the potential to reduce the burden on federal programs such as Medicare/Medicaid. For administrators of long-term care facilities, the program serves as an instrument for enhancing service quality, improving key metrics (quality metrics), reducing staff turnover, and fostering a more stable, therapeutically supportive environment. For clinicians — psychologists, geriatricians, and nurses — the model strengthens the role of mental health in geriatric practice by providing clear action protocols.

Prospects for further research are linked to formalizing the model as a certifiable, manualized program for scalable implementation. Conducting a large randomized controlled trial is necessary to validate effectiveness across different facility types and health systems, which will make it possible to establish the integrated psychotherapeutic approach as a new standard of elder care.

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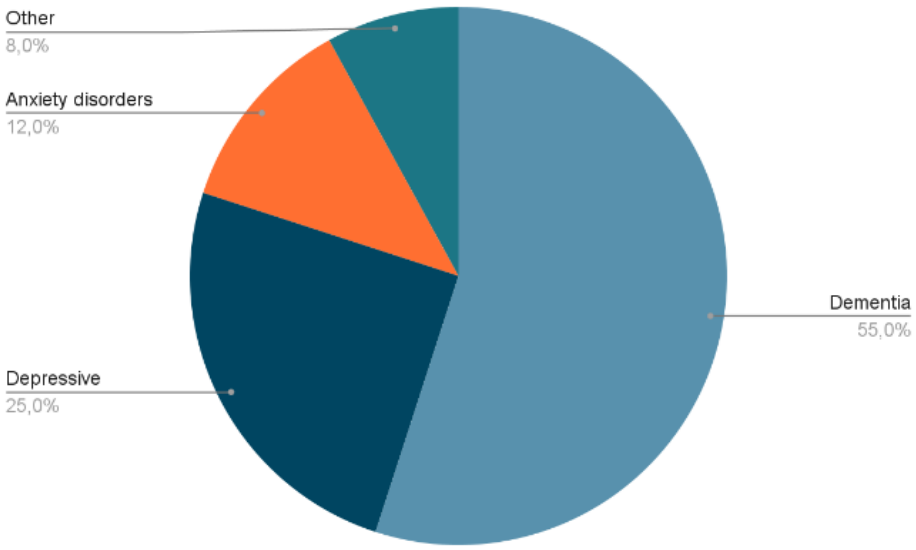
Figure -



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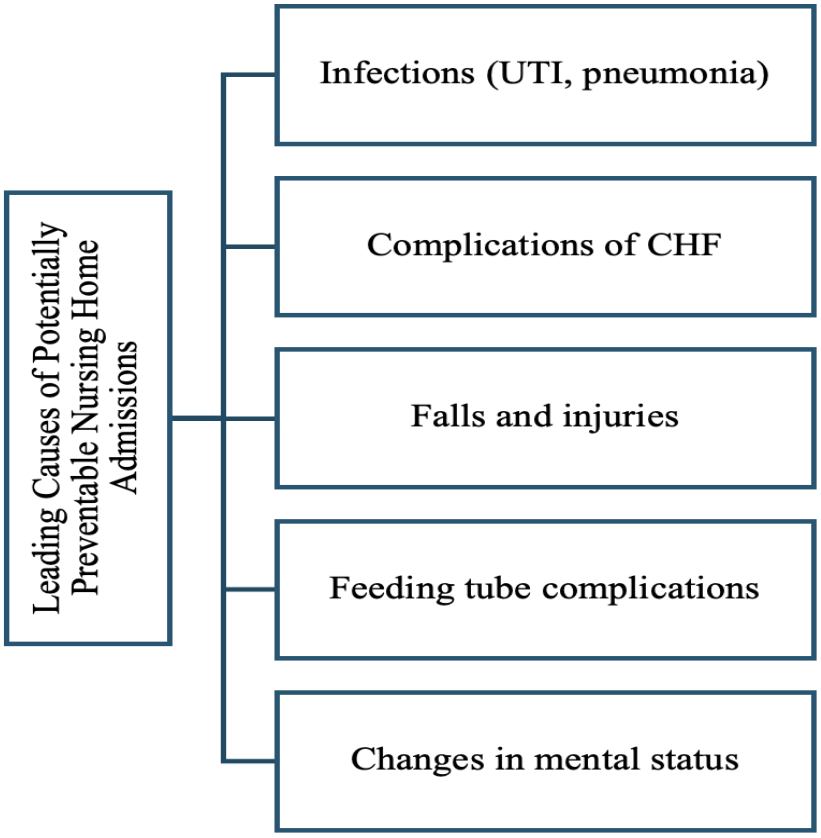

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