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Psychogeriatrics: How Mental Illness is treated among the Elderly

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Statement of the Problem

“Approximately one in four US seniors experience mental illness in any given year” (Adepoju, 2018, p.511). This percentage amounts to between 10 and 15 million senior citizens struggling with a mental illness at any given time, and all in a nation where as much as 60% of those citizens may not be receiving effective care for their conditions, according to Adepoju (2018). Mental illness can have severe adverse effects on a person of any age, let alone an elderly citizen, whose advanced age will most certainly pose additional problems for them both physically and mentally. These elderly populations are more at risk to develop coexisting conditions connected with mental illness like diabetes, hypertension, and heart disease. The care for these individuals has decreased both in effectiveness and in quantity as more and more elderly citizens begin to move to nursing homes and other long term care facilities with staff who are unable to handle the growing number and severity of their cases.

I chose this project because mental health in and of itself is a scourge on our population that is less focused on, even less so among the elderly. These disadvantaged populations are unable to make sense of their conditions, unable to cope with their symptoms, and unable to rely on their caretakers to provide efficient support in their time of need. As explained by Adepoju (2018), some efforts by the US government have been made to address these issues, including the Medicare Improvements to Patients and Providers Act of 2008 as well as the Affordable Care Act of 2010. These solutions, however, have done more to lower the cost of insurance or treatment in some of these cases, as well as increase the number of behavioral health providers involved, but don’t do enough to make change on a wider scale. In order to do so, the involvement of healthcare providers needs to be taken to the next step and generalized. The best solution to treating mental illness in elderly long-term care patients is for these facilities to

improve the education of their staff in terms of treating mental disorders by creating training programs and systematically reviewing results/progress in coordination with behavioral health providers.

Background of the Problem

Gerontopsychiatric patients as defined by Van der Wolf (2019) are “older people with chronic mental disorders,” who “require a combination of psychiatric and medical support” (p. 287). Long-term nursing home facilities are institutions designed to treat and house elderly patients, who cannot live independently, for prolonged or even indefinite amounts of time. As Jester (2020) notes, it is important to “identify NHs that serve large proportions of residents with [serious mental illness]” (p. 1313), as the density of residents in these institutions is an important factor in their care. Serious mental illnesses, or chronic mental disorders, are those in which the patient has trouble functioning in day-to-day life and who may even be unable to perform instrumental activities of daily life, which include necessary actions like bathing, feeding oneself, and using the restroom.

There are multiple factors in both the nation’s treatment of older adults and life in a long-term care facility as well as that contribute to an increase in mentally ill elderly living in nursing homes. One factor presented by Stobbe (2015) is that the quality of life within these facilities has an adverse effect on the motivations of gerontopsychiatric patients in the form of patient related factors, as well as relationship factors. Some of the former factors can include “greater severity of symptoms, higher level of substance abuse problems, lack of insight, male gender, younger age, and lower education” while the latter can include “lower therapeutic alliance and less family support” (p. 126). It is these factors that contribute to a low level of motivation for vulnerable patients, resulting in less effective care and a lower quality of life. The importance of the

patient's mentality is further corroborated by Kelemen (2018), who notes that "promoting mental health involves creating conditions for elderly people to enjoy life...and participating actively in social life" (p. 283). With this, Kelemen emphasizes that the deteriorating mentality of a mentally ill elderly patient can cause a shift in motivation, and that it may result in a decrease of involvement in all aspects of life, including that of the treatment plans provided by long-term care facilities. The motivation of a gerontopsychiatric patient due to the proportion of quality of life needs that they can receive is proportional to their involvement in treatment, and therefore proportional to the effectiveness of that treatment overall.

Another factor in the poor quality of care that these populations receive exists in the vast amounts of patients that are taken into facilities annually. As Jester (2020) notes, there exist some nursing home facilities that take on more patients with mental illness than others, and that these facilities "were found to report lower direct-care staffing hours, have a greater Medicaid-paying resident census, were more likely to be for-profit, and scored lower on all NH Compare star ratings in comparison to all other NHs" (p. 1312). This points to the large number of at-risk elderlies being another source of difficulty, as more citizens are continuously aging and entering nursing homes, increasing the proportion of residents with serious mental illness, an ongoing trend that caretakers are having difficulty dealing with. This point is emphasized by Van der Wolf (2019), who states that the reason for the facilities' inability to give efficient care is the ever-growing population of older adults who are continuously being sent to nursing home facilities. She also cites the "trend in Western society" of keeping elderly people in their own homes for as much time as possible as another factor (p. 287). This then creates a disproportionate number of patients being admitted all at once rather than in a natural progression, and with more severe needs at the start of treatment than they would have had if

they'd been admitted earlier. The sheer numbers of both present and soon to be gerontopsychiatric patients overwhelms long-term care facilities, making it much more difficult to allocate treatment and do so effectively.

Perhaps the most detrimental factor in the lacking quality of care in gerontopsychiatrics is the lack of care providers' education regarding mental illness detection and treatment. Svensson (2017) states that deficient abilities of detection are the most to blame, as in many cases mental illnesses like depression are associated with old age and seen as a natural occurrence, and therefore are not officially part of patient treatment or simply ignored altogether. Svensson notes that the ability of nurses to detect serious mental illness in long term care facilities revolves around screening, and that "standard screening routines in average recognizes less than 50% of cases that meet criterions in Structured Clinical Interviews for DSM disorders" (p. 595). Given the number of patients, many tasks like these are delegated to nurses, and when using methods with such low rates of success, it results in many not being diagnosed correctly and not receiving proper care. Borges-Saidel (2020) includes this point in her analysis of social representation of caretakers in these institutions, stating that "concern stems from both staff dimensioning and professional education for health care provision" (p. 3). A lack of education, according to Borges- Saidel, seems only to be a symptom of a larger threat for long-term care facilities—a lack of funding and resources. This means not only is there insufficient education to deal with these patient's complex needs, but resources to do so are lacking as well, such as staff and medical equipment. This only emphasizes the need to strengthen the ability of gerontopsychiatric caretakers through widespread policy change.

Author's Solutions

As Stobbe (2015) states in their article, the unmet needs of elderly patients with severe mental illness—whether they be physical, emotional, or social—are a deciding factor in the level of motivation for treatment that these patients have. According to a previous cross-sectional study, Stobbe states that “a higher level of unmet needs was associated with poor treatment motivation at baseline” (p. 126), and that along with this, the effectiveness of treatment dwindles as well. Previously, they had believed that motivation and needs existed in a linear relationship for patients, but further longitudinal studies indicate that there exist “distinct conceptualizations of motivation” (p. 130), meaning that motivation for treatment is not solely affected by unmet needs, and this creates a difficulty in keeping up with the patient’s status during treatment in order to increase their motivation. This idea is further emphasized by Van der Wolf (2019), who describes the broad nature of well-being, similar to needs and motivation in this case, as “deliberately broad and thus allows for literature from different theoretical perspectives” (p. 287), meaning that while assessing these individuals’ needs is difficult, it allows for the opportunity to do so using many different approaches. Fortunately, for such a complex issue, Stobbe has a complex answer as well. Through the inclusion of ACT teams, which are “a multi-disciplinary team staffed by a substance-abuse specialist, a rehabilitation worker, a social worker, a psychiatric nurse, a nurse specialized in somatic care, a community mental health nurse, and a psychiatrist specialized in care for older people” (p. 126), members will be able to focus solely on the mental health of these individuals and not on logistical issues like the number of patients needing to be cared for that day, or any other medical issues, leaving that up to the caretakers. In results of the longitudinal study, Stobbe found that the use of the ACT team for 70 individuals, from baseline to 18 months, was associated with “remaining motivated for treatment as well as becoming motivated” (p. 130), emphasizing the value of selective mental health care

that focuses on the patient's perceived needs and motivations. Some more hard-science focused individuals in the psych field may argue that motivation isn't in itself a cure of any kind and can't guarantee improved treatment or results, I would mention that not only does the study in question show positively-leaning data quite early in its conception, and that a positive outlook may not be the cure for mental illness, positive motivation is simply the key to allowing caretakers to use *other* forms of treatment more effectively with more cooperation and compliance from the client, which in *any* field revolving around mental illness, is hard to find. The topics of motivation and well-being are also being discussed among others in the field who aim to tackle the senior mental health issue.

Though a much more novel field, the clinical application of meditation, which arrived in the US in the 1970s has become a topic of debate for the treatment of chronic severe mental health issues. Having been used originally for those suffering from chronic pain, meditation soon began to expand into the populations of those with anxiety or anxious tendencies around this time. Hayasi (2020) explains how it became known as "Mindfulness-Based Stress Reduction Therapy...and is a model for several adaptations made in research studies" (p. 3). This marks the beginning of the consideration of mindfulness and mental health to be linked in a positive way, and the possibility to use these mindfulness interventions for psychiatric care and well-being became the topic of conversation. Just as Van der Wolf (2019) corroborated in the previous section, they also go into depth about the factors that make up an individual's psychological well-being, and how it is extremely important to overall health. They introduce the idea of certain "determinates" associated with the level of well-being in patients, including conditions such as "socioeconomic status...high-quality social ties, self-perceived health, functional status, and marital status" (p. 287) all of which can play a role in a patient's life satisfaction. These

mindfulness interventions can be used in a variety of ways to treat a variety of complex issues, usually in the form of programs that last over multiple months in which clients practice mindfulness meditations with professionals on a weekly basis. As Hayasi mentions, it shows promising results for areas such as psychoactive substance abuse disorders, where it's been deemed "possibly effective" by researchers, as well as cases of psychological stress, where mindfulness is described as having "positively influenced the practitioners' well-being and quality of life, increasing acceptance, observational abilities and self-compassion" (p. 6). These are only two instances, and niche ones at that, wherein this intervention strategy has been effective, meaning that it could hold potential effectiveness for many other conditions as well. Those in the field of psychiatry that are more conservative and skeptical of more contemporary approaches to treatment may argue that meditation isn't enough to battle most cases of severe mental illness, and loses out against other approaches such as cognitive therapies and drugs, and while I'd be inclined to agree, the importance of mindfulness meditation is not in what it can do by itself, but the ways it can work to supplement these other treatments and become a key part of the patient's daily life so as to allow them to independently monitor and workshop their psychological well-being without having to rely on medications and therapy forever. Other approaches to treating mental illness in the elderly have focused less on mindfulness and more on how the current caretaking system can be changed to better fit the needs of these individuals.

One possible issue that gets in the way of getting patients their treatments is the cost and inefficiency of the typical model for elderly health care. Costs are too high to be financially feasible for patients and due to the overall impersonal environment of a long term care facility, visits to these institutions increases, creating a loop of constant use of medical care followed by the large costs associated with it. Bowdoin (2018) suggests a solution centered around making

advanced primary care more personal and less expensive known as the Patient Centered Medical Home model (PCMH). They describe the PCMH model as “a team-based model of primary care that is comprehensive, patient-centered, coordinated, accessible, and committed to quality and safety” (p. 574) that aims to improve patient outcomes and contain costs of care. Adepoju (2018) supports these goals by emphasizing the financial difficulty those with SMI go through, stating that adults with depression “visit the doctor and emergency department more often, use more medication, incur higher outpatient charges, and stay longer in the hospital” (p. 511) only furthering Bowdoin’s claims that cost is a key factor in the difficulty of getting treated effectively. According to some studies, the PCMH is associated with “decreases in use of high-cost services, such as hospitalizations and ER visits, and increases in mental healthcare and low-cost services” (Bowdoin, 2018, p. 574) and the results of a retrospective records review show that those using the model “had a lower probability of inpatient hospitalization from the ER than patients who did not” (p. 575). These early findings show us that the PCMH is able to achieve better results when it comes to treatment for those under severe psychological stress, and that the containing costs aspect has potential but still needs further research done to prove its viability. Conservative taxpayers may worry that because this model takes the cost away from the patients that it must end up somewhere, namely in increased taxes themselves. While I accept that as a potential truth, it needs to be stated that while these increases could very happen, the long-term effects of decreased costs/uses of medical care would be enough to make up for it. The topic of money as a finite resource brings up another solution brought up by others in the field of medical care.

Resources are the fundamental tool in the care for mentally ill seniors, and over time, those resources, namely staffing numbers and management positions have dwindled in the face

of ever-increasing numbers of patients needing to be treated. Borges-Saidel (2020) cites studies on the perception of health care workers on their ability to treat these populations and has come up with multiple facets of the system that are in need of assistance. Within these perceptions they mention that “the lack of strategies for routine care is discussed...The burnout of mental health professionals emerges, and the perception of the lack of human resources is revealed in the discourses” (p. 1), it is these areas in which professionals perceive that they don’t have enough resources to care effectively for patients, the low amount of staff they have not only increases the ratio of patients to caretakers, leading to rushed care, but also creates burnout and strain on the workers themselves. Jester (2020) corroborates these challenges in their own study of the relationship between patient density and care in nursing facilities, stating that “these “high-SMI” NHs report lower quality of care on a number of metrics” (p. 1317) and that they are much more likely to use outdated measures of care like restraints to cope with the inability to treat so many patients with SMI. Both sources clearly dictate a need for resources not only due to increase the effectiveness of patient care, but to take the extra stress off previously overworked staff. One solution to gain the additional resources needed for increased staffing, etc put forth by Jester could be “incentivizing states to increase Medicaid reimbursement rates and tie these rates to staffing increases” (p. 1318) allowing for more funds to be allocated to these areas of need. Some more conservative taxpayers and politicians may ask where these funds would actually end up coming from, and to that I give Jester’s possible solution, but also the possibility for others, like the military budget for instance which already uses a lot of money annually. We’ll need to allocate funds from a separate government program or increase taxes in order to take these measures, we simply have to decide which option suits us best. Other approaches to dealing with

mental illness in the elderly focus on social connectedness and ability to create networks to help cope with SMI.

Some individuals believe that the answer to combating the difficult task of treating SMI in the elderly is to create a network of systems to integrate care across multiple platforms. Kelemen (2019) states that in order to treat these individuals we must care for them on more than one level using different institutions simultaneously. The solution requires the creation of networks made to “support elderly people with a mental health problem, so as to help them to live a decent life, to socialize, to feel useful and accepted, with special focus on the improvement of their lives” (p. 158), that way we are creating a complex relation between medical care, therapeutic care, and home care to give the patient the most effective treatment possible, without the previous issues of any one of these institutions not having enough info or conflicting with another. Svensson (2017) adds on to this theory by mentioning that in some cases the level of nursing staff is less than adequate to identify some issues, they stated that “a review shows that nurses’ standard screening routines in average recognizes less than 50% of cases that meet criteria in Structured Clinical Interviews for DSM disorders” (p. 595) meaning that with a complex network of peoples working together to improve care for one patient, these kinds of logistical errors that are affecting one institution can be covered by others, and vice versa. Some in the psychiatric community may ask why this would be beneficial compared to the typical use of medications and so forth, and to that I’d say that by creating a more complex relationship between multiple aspects of someone’s care, each separate institution will now have resources, opportunities, and options for care that they didn’t have previously, making it easier for them to mold their efforts to fit the individual’s needs. While some of the previous solutions have shown

promise, others have taken a more fundamental approach to the issue and may have created a more viable option in doing so.

The ability to recognize, diagnose, and treat symptoms of mental illness is expected by many to be a widespread knowledge for those in the medical field, however in many cases, knowledge of SMI is seen to be dwindling in areas where it could be harmful. In an effort to assess the knowledge and skills of current staff, Kelemen (2018) conducted a study in which medical students were assessed for these abilities to determine what kind of perceptions they'd be bringing into their careers. It was found that "students, especially those from pedagogy do not know the issues faced by older people and do not know issues related to mental illness" (p. 287), meaning that perhaps education itself is the key to improving care for elderly dealing with SMI. That view is shared by Svensson (2017), who describes the issue as "a high prevalence of mental illness and a scarce detection of the conditions together with perceived barriers to seek help lead to insufficient treatment and lower quality of life" (p. 595), and that in order to fix these problems we must create routines for care that allow general health care staff to be better equipped for not only correctly identifying illnesses but treating them as well. The solution in Svensson's perspective is to incorporate the Mental Health First Aid (MHFA) training program to help better educate students and staff about these topics. According to Svensson, "Mental Health First Aid (MHFA) training is an educational program developed in Australia...aimed to improve knowledge about mental illness for the public and provide skills in order to improve their readiness to mediate appropriate help to persons in need" (p. 596), and the knowledge in this program, able to be adjusted for all age demographics, will help staff to increase their knowledge, confidence, and readiness to be able to assist elderly patients with SMI, as well as improve their attitudes towards working with these populations. After a 6-month study was

conducted assessing the usefulness of the knowledge given in the course, changes seen were described as positive in the case of confidence, knowledge, and attitude towards helping out those with SMI. On a wider scale, the results of the test-run of the program were stated by Svensson to be as follows:

Most elements trained in the MHFA course show positive changes at the six-month follow-up. To make contact, taking time and listen non-judgmentally, ask about suicidal thoughts, give information about effective treatment and where to find it, to recognize symptoms and assess risks are aspect that show significant improvements. (p. 599)

Some individuals in the field who see the issue to be more focused on high density of SMI patients in nursing homes may question whether including extra training will really help a staff that is already typically overworked due to a high number of patients. I would answer that question by pointing out that a large factor for the stress felt by staff is not only due to numbers, but an inability to treat patients, and this training program would work to eliminate one of these root causes for staff while increasing their efficiency and effectiveness, and not affecting too many in the healthcare system with a radical systematic change.

Author's Conclusions

If Stobbe (2015) and Van der Wolf (2019) solutions are utilized and a focus on unmet needs is taken, then we will see increases in treatment motivations for elderly patients with SMI and improved outcomes of care. If Hayasi (2020) and Van der Wolf (2019) solutions are utilized, and mindfulness meditations become common in treatment, we will see a decrease in severe psychological stress in elderly patients and improved outlooks, leading to better results. If Bowdoin (2018) and Adepoju (2018) solutions are utilized, and a patient-centered medical home model becomes the standard, we will see less costs for medical care for these populations

decrease over time as well as financial burdens, and elderly people with SMI will have better care not plagued by money. If Borges-Saidel (2020) and Jester (2020) solutions are utilized, and resources are allocated to increase staffing in care facilities, we will see a decrease in stress from these staff members, and an increase in the efficiency of care for patients, followed by improved outcomes as well. If Svensson (2017) and Kelemen (2019) solutions are utilized, and the development of social networks takes priority, then we will see improved results for SMI patients and decreased pressure put onto individual institutions. If Svensson (2017) and Kelemen (2018) solutions are utilized and a Mental Health First Aid training program is put to use, then we will see an increase in the confidence, ability, and effectiveness of nursing staff who treat elderly SMI patients, as well improved outcomes.

Gaps in the Research and Future Recommendations

While many of these studies show promising results, there are some instances where they may have made some errors or miscalculations for any number of reasons. For the studies conducted by Svensson (2017) there were multiple aspects that could have possibly skewed some of the results: first, that not accounting for the prior education of individuals in the program could pose a risk by creating more situations where no knowledge was reported to have been gained despite the validity of the content, and second, that instructors used in the pilot study were inexperienced at teaching in this kind of program, and more experienced ones should be used for future studies to see whether a difference could be made. I also expected to see more results related to actual patient care and perception in the study done by Svensson and believe that area would need additional surveillance in future studies. I also expected that the study of medical students done by Kelemen (2018) would have stratified its populations more, assessing students of different

levels and disciplines to see if there would be any common denominator for issues in education, and would recommend that as a possible addition to future studies.

My “Bill Gates” solution to treating mental illness in the elderly would align mostly with the solutions presented by Svensson (2017) and Kelemen (2018), but on a larger scale. With unlimited ability and resources, I would make mental health education a constant in many more institutions, including middle school education, high school education, and college education, as well as allocate more funds towards mental institutions in general as and nursing facilities; that way the general public would have a more in depth understanding of SMI and there would be less stigma surrounding the topic. This would help change people’s attitudes about mental illness and hopefully make signs more noticeable by the average person or family member, leading to people getting treatment earlier instead of creating a bottleneck of mentally ill elderly patients who weren’t diagnosed until they reached a nursing facility. With these changes, we could not only improve the lives of those already in care for SMI, but work to solve the problem from the root instead of dealing with the consequences.

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