# Geriatric Mental Health in Rural Long-Term Care: Challenges and Opportunities


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*Experienced geriatric behavioral health providers*

# John in Smalltown America

* Year: 1988
* 75 year-old-Caucasian male
* Retired from small engine repair
* Lives at home with wife in small country home

# John in Smalltown America cont.

* Sister: Alzheimer's disease, died 2 years ago in late stages
* Recent complaints of forgetfulness, confusion
* PCP: revealed Alzheimer's diagnosis
* Small stature wife couldn't care for him alone
* Solution: Weekdays at town nursing home, weekends at home (!)
  * No local mental health resources
  * No mental health providers available to nursing facility
* John: longtime hunter, gun aficionado
* Son-in-law and grandson removed all ammunition, allowed guns to stay (great sentimental value)

# John in Smalltown America cont.

* Nursing home: John kept to himself, ate sparingly, complained often of failing memory, often asked where his room was
* Nursing home physician (also town's PCP) noted a rather quick decline in cognitive functioning after initially sudden onset
* Wife noted middle-of-the-night awakenings on weekends John was home

# John in Smalltown America cont.

* One Saturday afternoon
  * Wife hears a door slam from kitchen, worried John has fallen
  * John unable to be located in the house anywhere
  * After several minutes of searching, John found on the floor of his outside shed… having shot himself in the head with a pistol
* Discovered that prior to removal of ammunition, he had held back one bullet, hid it, and located it when he planned to use it
* Pistol: modern 9 mm, complex action, multi-step loading and firing process

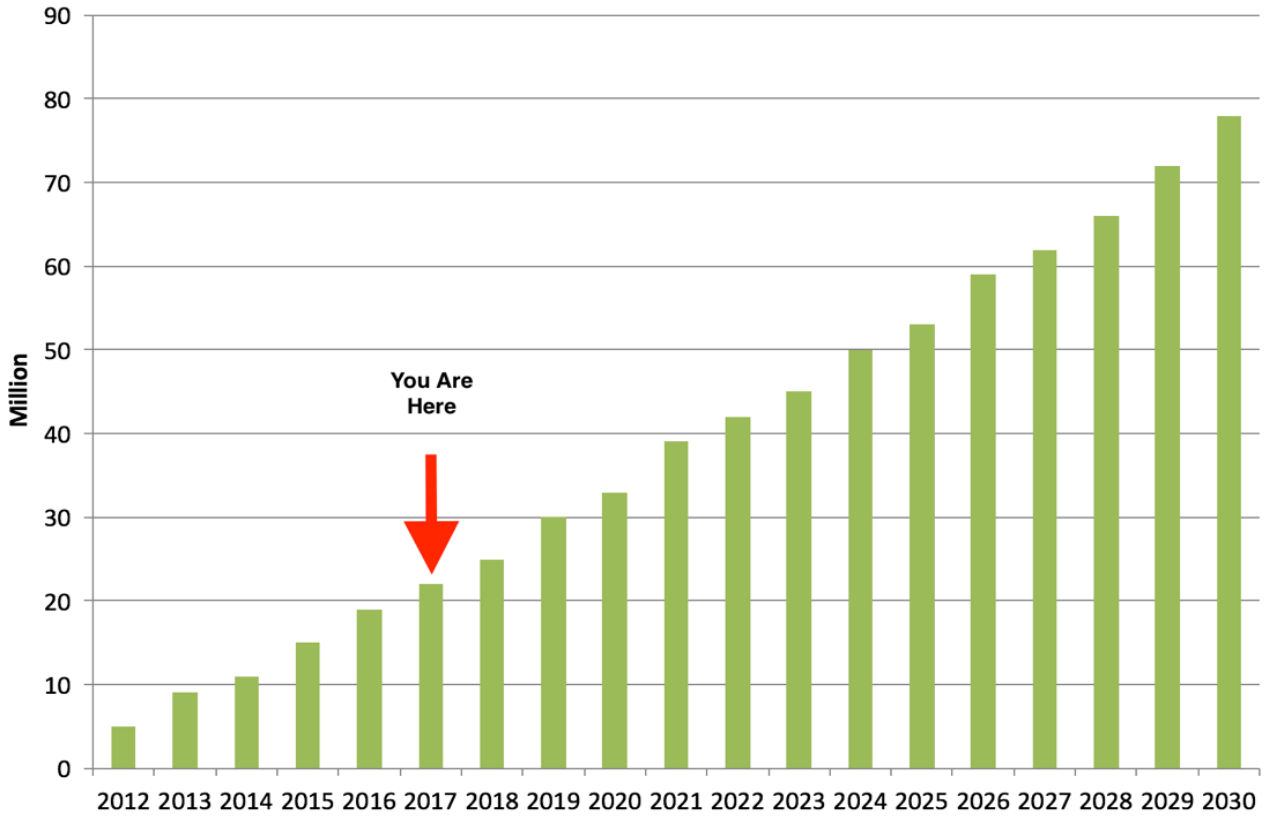
# John in Smalltown America cont.

* In retrospect: was it Alzheimer's disease?
* Likely pseudodementia (depression)
  * Planning ability, sequencing intact; ongoing awareness of specific "deficits", sleep disturbance
  * Completely treatable
  * Cognitive impairment often reverts to baseline when successfully treated

# Overview

* Trends and context for older adult MH care
  * Population trends
  * MH trends
  * Rural considerations
  * LTC considerations
  * Workforce issues
  * Myths and realities
* Strategies for success

# Age Wave: U.S. Over Age 65



# Prevalence of Mental Health/Substance Use Issues in Older Adults (IOM, 2012)

| Mental Health or Substance Use Condition | Prevalence Rate[a] (%) | Estimated Number of Older Adults in 2010[b] (Millions) |
|---|---|---|
| **Mental health conditions** | | |
| Bipolar disorder | [c]-0.2 | [d]-0.1 |
| Schizophrenia | 0.2-0.8 | 0.1-0.3 |
| Obsessive-compulsive disorder | 0.8 | 0.3 |
| Depressive symptoms | 1.1-11.1 | 0.4-4.3 |
| Anxiety symptoms | 4.3 | 1.7 |
| Suicidal ideation | 0.5-1.7 | 0.2-0.7 |
| Suicide plans and attempts | [c] | [d] |
| **Substance use conditions** | | |
| At-risk drinking | 5.2 | 2.0 |
| At-risk drug use | 0.9 | 0.4 |

# Prevalence of Mental Health/Substance Use Issues in Older Adults (IOM, 2012) cont.

| Condition | Prevalence Rate (%) | Number of Residents with the Condition |
|---|---|---|
| **Mental health conditions** | | |
| *Depression* | 49.6 | 590,834 |
| Anxiety disorders | 16.1 | 192,071 |
| Bipolar disorder | 2.8 | 33,416 |
| *Schizophrenia* | 3.6 | 42,521 |
| **Summary figures** | | |
| One or more conditions | 56.8 | 675,622 |

# MH and Older Adults: Practical Issues

* OA less likely to visit outpatient clinics (preference or ability)
* Stigma of MH conditions and treatment discourages seeking help
* OA less familiar with mainstreamed MH language (e.g., ”psychotropic”, “processing”, “trauma”)
* Adherence to medical model of illness
  * Visible injury or illness
  * Single point of care
  * Medication as singular intervention

# Pillars of Effective MH Services (HRSA, 2011)

* **Availability** includes the staffing or service shortages limiting the receipt of services,
* **Accessibility** addresses the knowledge of when and where to obtain services, including coordination of services across sectors of the health and social service system, as well as the travel issues which may be involved,
* **Affordability** involves the costs associated with receiving care and availability of benefits/insurance to offer services, and;
* **Acceptability** incorporates the persistent issues related to the negative perception and stigma attached to the need for services

# Healthcare in Rural America

- Positives:
  - Close-knit communities
  - Flexible problem-solving approaches
  - Personal concern for neighbors
- Challenges:
  - Few healthcare resources
    - Practitioners, specialists
    - Emergency care options
    - Facilities (type and number)
  - Distance and transportation issues
  - Less experience with mental health sector
  - Potential visibility for those seeking MH help

# MH In Rural America

* 65% of non-metropolitan counties in America do not have a psychiatrist
* 47% do not have a psychologist (Andrilla et al., 2018)
* Suicide rates higher in rural areas (CDC, 2016)
* Approximately 20% of rural individuals have some form of mental disorder (Mohatt, Adams, Bradley, & Morris, 2006)

# Mental Health in Long-term Care

* Rates of virtually every form of mental illness are higher in long-term care environments (especially depression) than in the community
* Mental illness most often complicated by medical illness
* Few clinicians available with specialized training with this complex population
* Regulatory environment
  * Antipsychotic reduction (CMS)
* Economic considerations
  * MH parity
  * Medicare assignment, coverage restrictions

# Mental Health in Long-term Care cont.

* Inpatient psychiatric treatment
  * Continually shrinking number of available geriatric beds statewide
  * Pressures to decrease length of inpatient stay
  * Selectivity of private inpatient beds
* Few step-down options from inpatient hospitalizations
* Few crisis stabilization (i.e., sub-acute) beds available

# Mental Health in Rural LTC

* Medicare recipients in rural areas receive fewer MH services than those in metropolitan areas (Shea, Russo, & Myer, 2000)
* Vast majority of rural MH services for LTC residents provided by primary care (i.e., family practitioners and geriatricians; Doescher, Skillman, & Rosenblatt, 2009)

# Workforce Issues

* Primary Challenges in the Recruitment of Geriatric MH/SU Specialists (IOM, 2012)
  * Stigma against mental health and substance use (MH/SU) and aging
  * Lack of financial incentives to practice in geriatric MH/SU
  * Limited opportunities for specialization
  * Inadequate early career support and mentorship

# Psychiatrists

* Primarily provide diagnostics and medication management
* Psychiatrists in practice declined 10.2% between 2003 and 2013, while physicians overall in practice rose 7.7% between 2008 and 2013 (Thompson, Flaum, & Pollack, 2017)
* Number of psychiatrists seeking geriatric fellowship in steep decline since 2001—changes in visa rules post 9/11
* Over 50% of all psychiatrists do not accept insurance (Bishop et al., 2014)
* By 2030
  * Number of geriatric psychiatrists available: 2640
  * Number needed: 4000-5000 (National Institute on Aging, 2012)

# Nurse Practitioners

* Have recently made strides in Virginia toward independent practice
  * APRNs with 5 years' experience in collaboration with a physician are now eligible for independent (non-supervised) practice as of July 1, 2018
* Psychiatric NPs (APPNs) primarily provide medication management
* APPNs are legally able to prescribe the array of psychotropic medications
* Some APPNs may provide psychotherapy
* APPNs are currently fewer than psychiatrists, although they are generally more available in rural reaches than psychiatrists in Virginia (Hanrahan & Hartley, 2008)
* Overall fewer APPNs per 100,000 in Virginia (3.1) than psychiatrists (11.3), psychologists (27.5), and social workers (36.2)

# Psychologists

* Provide diagnostics, behavior management programs, and various types of psychotherapy
* Only 4% of psychologists specialize in geropsychology, yet by 2030 older adults will comprise 20% of the U.S. population (Hoge et al., 2015)
* Currently in Virginia: Only 3 board-certified geriatric psychologists
* Nationwide: 66 board-certified geriatric psychologists (board created in 2014)
* Most care provided to older adults in LTC is by non-specialist psychologists who practice geropsychology only on a part-time basis (training and experience vary widely)

# Social Workers

* LCSWs (master's level, licensed) provide psychotherapy and care management/coordination
* 2% fewer social workers will be available by 2025 than in 2013; the problem is compounded by a steeply rising need for services (HRSA, 2013)
* Psychiatric social work is the largest specialty among all licensed social workers (NASW, 2006)

# Common Beliefs: Fact or Myth? cont.

* Belief: Geriatric mental health is no different than any other population
* Verdict: (Enormous!) Myth
  * Even within the same diagnosis (e.g., Bipolar Disorder), symptoms often express differently between younger and older adults
  * Physical illness often produces mental status changes, mimicking psychiatric symptoms
  * Geriatric mental health requires a multidisciplinary or (preferably) interdisciplinary team approach as opposed to a solo practitioner approach

# Common Beliefs: Fact or Myth?

* Belief: All old people get_____ (depressed, dementia, anxious)
* Verdict: Myth
  * None of these are considered to be the norm. Normalizing these disorders/symptoms decreases the likelihood they will be attended to and appropriately treated.

# Common Beliefs: Fact or Myth? cont.

* Belief: Appreciating diversity is not as important in geriatric mental health
* Verdict: Myth
  * 65 y.o. is very different than 95 y.o. (age)
  * Rural vs. urban backgrounds (geography)
  * Cultural background is just as arrayed in older adults as in younger adults (ethnicity)
  * Socioeconomic status will often create relevant clinical differences between individuals (demographic)
  * Sheer length of life trajectory differentiates individuals from one another (i.e., two individuals at birth are far more similar to one another than two 70-year-olds) (longitudinal)

# Common Beliefs: Fact or Myth? cont.

* Belief: Substance abuse is not a problem in older adulthood.
* Verdict: Myth
  * Upwards of 11% of all medical hospitalizations are the result of substance abuse or misuse
  * Equal frequency: alcohol-related hospitalizations vs. heart attacks
  * Prescription misuse and abuse rates are on the rise in the elderly, particularly opoids

# Common Beliefs: Fact or Myth? cont.

* Belief: Residents who have psychiatric or behavioral problems need psychotropic medications
* Verdict: Depends
  * All medications must be used cautiously with older adults
  * Potential for sensitivity, side effects, polypharmacy is very high in the geriatric population
  * In many cases, non-medication interventions are preferred first-line interventions because of the risks drugs often pose (e.g., depression, anxiety, trauma)
  * Beers Criteria: A large list of inappropriate medications for older adults (based on research and experience); published by American Geriatrics Society, most recent update in 2015

# Common Beliefs: Fact or Myth? cont.

* Belief: State geriatric hospital beds are a long-term placement
* Verdict: Myth (used to be true)
  * State hospitals adhere to a treat-and-discharge model, similar to medical hospitals
  * Sometimes individuals are in facilities because of extreme barriers to discharge (e.g., finances, legal issues) but there are regulatory and financial pressures for prompt discharges from public and private facilities alike
  * However, length of stay in state facilities is generally longer than in private facilities

# Common Beliefs: Fact or Myth? cont.

* Belief: If an individual's behavioral problems are caused by dementia, they are not eligible for a TDO to a psychiatric facility
* Verdict: Debatable
  * **§ 37.2-809 [a person is eligible for TDO if that person]** (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs; (ii) is in need of hospitalization or treatment; and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.

# Strategies for Success for MH in Rural LTC

* Telepsychiatry
* Training existing staff
* Program and organizational consultation
* Collaboration and networking

# Telepsychiatry

- Video-interfaced evaluation between prescriber and patient
- Various private companies offer service, often including equipment
- Insurance companies beginning to offer service codes for this procedure specifically
- For certain applications, initial results are encouraging
  - MD evaluation and management (E&M; i.e., medication management)
  - Triaging services to other professionals
  - Family education
- Limitations: Difficult to use video interface for more complex problem-solving
  - Multiple collateral staff interviews
  - Environmental assessments
  - Psychological testing (although new models are being developed to help accommodate this)

# Training Existing Staff

* Outlook is bleak for creating new specialists (psychiatrists, psychologists, NPs, social workers)
* ”Training up” existing LTC personnel—nursing staff and administration--is an essential component of successful MH management
* Key training topics:
  * Normal vs. pathological aging
  * Symptom manifestation and recognition
  * Verbal de-escalation strategies
  * The “Three Ds”: Dementia, delirium, and depression
  * Relationship between mental health and the law (TDOs, involuntary commitment, surrogate decision-making, etc.)
  * Caregiver burden, stress management, and self-care

# Program and Organizational Consultation

* Reactive: Post-survey deficiency plans of correction
* Proactive: Thoughtful policy and procedures that outline facility responsibilities re: behavioral health issues
* Key topics:
  * QA/QI for mental health issues
  * Risk management strategies (e.g., aggression and suicide risk assessments)
  * Criteria/threshold for pursuing TDO or psychiatric hospitalization
  * Acceptable and prohibited behavior management techniques
  * Nonpharmacological behavior management strategies/programs to reduce antipsychotic usage
  * Multidisciplinary/interdisciplinary care practices and related communication strategies

# Collaboration and Networking

* Fundamental component of an effective continuum of care: TRUST
  * Despite each's unique pressures they face, all entities involved in residents' care must be able to trust that all are operating in good faith
  * Frequent reminders: Everyone wants the same outcome: High quality of life and safety for all residents in LTC
* Familiarity breeds contempt? Nope. Familiarity breeds trust!

# Collaboration and Networking cont.

* Grass roots initiatives
  * Piedmont CSB Consortium—produced this conference!
  * Virginia Geriatric Mental Health Partnership (Richmond-based, representing all regions)
  * Key participants:
    * Professional associations (e.g., VHCA, VHHA)
    * Public entities (e.g., CSBs, state hospitals, DARS, DSS)
    * Private providers (e.g., ALF & NF reps, solo clinicians)
    * Advocacy groups (e.g., ombudsman, Virginia Poverty Law Center)
    * Elderlaw attorneys
    * Local hospital reps
    * Geriatric Care Managers

# Collaboration and Networking cont.

* Grass roots initiatives cont.
  * Share case examples
  * Share care models
  * Share relevant developments at Federal, State, and Local levels
  * Sponsor and conduct exploratory projects (e.g., recent antipsychotic usage in Virginia ALFs)
  * Sponsor training series (e.g., GMHP Webinar Series): https://www.worldeventsforum.net/mhati/
  * Collaborate on specific cases, struggles
  * Conduct legislative advocacy
* Overall goal: Create a continuum of care with multiple points of entry

# Revisiting John

* Points of systemic failure:
  * **Availability**—No agency to accommodate midway between home and NF; research not yet plentiful re: depression vs. dementia
  * **Accessibility**—No MH services available to agency or resident; antidepressants not yet mainstream
  * **Affordability**—At that time, most mental health services were not covered by insurance or Medicare
  * **Acceptability**—Even if services were within reach, would a proud man born in 1913 have been open to services?

# Revisiting John cont.

* What if…
  * …nursing home staff had been trained to recognize depressive symptoms?
  * …home health care or an assisted living environment (memory care?) were available to him?
  * …professional clinicians had access to more detailed research re: depression vs. dementia?
  * …telepsychiatry services were available to him in the nursing home?
  * …his generation were able to openly discuss emotions and willing to seek help when needed?

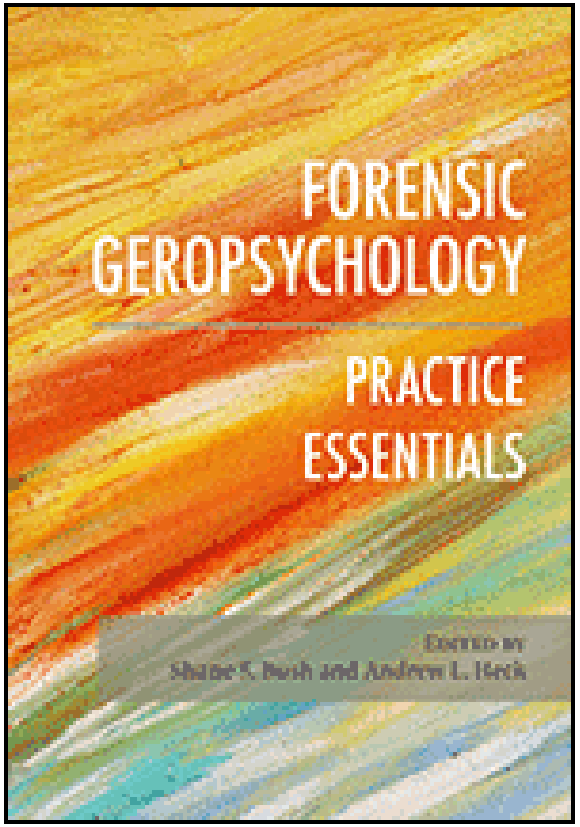
# Summary

* Residents in rural LTC settings who need MH services have historically faced significant disadvantages compared to metropolitan counterparts
* New geriatric MH specialists are not keeping pace with rising service need
* Successful MH treatment will need to be creative (e.g., technology-based interventions), competent, conscientious (e.g., minimizing risks), collaborative and coordinated, and cost-conscious and cost-effective.

*Forensic Geropsychology*

Bush & Heck, eds. (2018)

http://www.apa.org/pubs/books/4317478.aspx?tab=2

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