Original

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Psychogeriatric care in times of COVID. Lessons learned and proposals for similar situations

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ABSTRACT

Introduction. The objective is to describe the problems related to outpatient psychogeriatric care in the context of the SARS-CoV-2 pandemic, as well as the proposed and implemented solutions for optimizing care for elderly people with mental disorders during the pandemic, that can also be applied in emerging similar situations in the future.

Methods. Data on healthcare provision and clinical problems in psychogeriatric practice over the course of one year of the COVID-19 pandemic were collected as the basis for proposals for action by a consensus of psychiatrists expert in psychogeriatrics. Setting: Outpatient psychogeriatric care services in the Madrid region, Spain.

Results. Eight topics relating to difficulties in the provision of psychogeriatric care were identified (access to services, treatment adherence, referrals and contact, continuity of care, isolation, nursing homes and laboratory tests) and agreement was reached on 14 possible solutions. In addition, 7 clinical problems of particular relevance were identified (bereavement, sleep, psychopharmacological treatments, physical, cognitive-behavioural and social deterioration, and violence) and 17 possible solutions proposed.

Conclusions. The SARS-CoV-2 pandemic poses a high risk to life for the geriatric population. Measures such as lockdowns and limiting contacts, exert a direct risk to mental health and an indirect risk due to greater difficulties in accessing psychogeriatric care. It is necessary to detect these situations and implement changes in how care is provided to this highly vulnerable population. We propose a series of possible solutions to the problematic situations detected that may be helpful in a variety of psychogeriatric care contexts.

Keywords: COVID-19, psychogeriatric care, elderly mental health, telepsychiatry, continuity of care

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ATENCIÓN PSICOGERIÁTRICA EN TIEMPOS DE COVID. LECCIONES APRENDIDAS Y PROPUESTAS PARA SITUACIONES SIMILARES

RESUMEN

Introducción. El objetivo es describir los problemas relacionados con la atención psicogeriátrica ambulatoria en el contexto de la pandemia SARS-CoV-2, así como las soluciones propuestas e implementadas para optimizar la atención a las personas mayores con trastornos mentales durante la pandemia, que también pueden aplicarse en situaciones similares emergentes en el futuro.

Metodología. Se recogió información sobre prestación de asistencia sanitaria y problemas clínicos en la práctica psicogeriátrica durante un año de la pandemia de COVID-19 como base para propuestas de actuación por consenso de psiquiatras expertos en psicogeriatría. Entorno: servicios de atención psicogeriátrica ambulatoria en la Comunidad de Madrid.

Resultados. Se identificaron ocho temas relacionados con las dificultades en la prestación de la atención psicogeriátrica (acceso a los servicios, adherencia al tratamiento,

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derivaciones y contacto, continuidad cuidados, aislamiento, residencia de ancianos y pruebas de laboratorio) y se llegó a un acuerdo sobre 14 posibles soluciones. Además, se identificaron 7 problemas clínicos de especial relevancia (duelo, sueño, tratamientos psicofarmacológicos, deterioros físico, cognitivo-conductual y social, y violencia) y se propusieron 17 posibles soluciones.

Conclusiones. La pandemia de SARS-CoV-2 supone un elevado riesgo vital para la población geriátrica. Medidas como el confinamiento y la limitación de contactos, ejercen un riesgo directo para la salud mental y un riesgo indirecto debido a las mayores dificultades para acceder a la atención psicogeriátrica. Es necesario detectar estas situaciones e implementar cambios en la manera de proporcionar atención a esta población altamente vulnerable. Proponemos una serie de posibles soluciones a las situaciones problemáticas detectadas que pueden ser de ayuda en diferentes contextos de atención psicogeriátrica.

Palabras clave. COVID-19, atención psicogeriátrica, salud mental de ancianos, telepsiquiatría, continuidad de la atención.

INTRODUCTION

In 2020, the new pathogen SARS-CoV-2 caused a global pandemic of the disease known as COVID-19. The pandemic has had a profound impact on morbidity, mortality and the economy, leading to significant changes in habits and customs around the world. The healthcare sector has been forced to adapt to SARS-CoV-2.

Care for psychogeriatric patients has been strongly influenced by the high risk of morbidity and mortality among these patients if they contract COVID-19. On the one hand, old age is an independent mortality factor in this disease[1] On the other, patients with mental illness tend to have many risk factors which can increase morbidity and mortality from COVID-19[2].

Social distancing and restricted visiting measures imposed during lockdowns can exacerbate emotional distress, depression and anxiety and generate lasting feelings of helplessness and fear of contracting COVID-19, causing the risk of unmet psychological needs to rise in the elderly population[3]. A study of psychogeriatric patients found that 37.7% of patients reported a worsening of their existing symptoms and 20.8% reported new mental symptoms[4].

Unfortunately, the measures taken to control the pandemic have resulted in a reduction in care for psychiatric patients in many locations[2]. which has led to rethinking Mental Health services[5,6] in order to meet the care needs of these patients in general, and of the elderly in particular, guaranteeing quality care without increasing the risk of contagion by SARS-CoV-2. In order to provide adequate clinical care to psychogeriatric patients, specialized interventions must be established[6] both in face-to-face care and telematics, called telemedicine.

Telemedicine involves the use of information and communication technologies to provide care at a distance outside traditional healthcare contexts[7]. Its use in psychiatry, known as telepsychiatry, has been acknowledged as a tool for reducing pressure on healthcare services and limiting the risk of contagion, ensuring continuity of care for psychiatric patients[8]. Although it is not without problems, this type of care could allow the provision of standard care[4] and reduce the risk of decompensation and hospitalization[9].

It is likely that care for psychogeriatric patients will need to be modified during the pandemic to allow greater flexibility[10], without overlooking the importance of continuing to deliver quality psychogeriatric care and minimizing the risk of contagion for patients and professionals.

This article is the product of an initiative by a working group of psychogeriatric experts in Madrid (Spain), who shared the difficulties they had encountered and the solutions they had adopted to address them after a year of experience in caring for psychogeriatric patients during the COVID-19 pandemic.

METHODS

The Madrid Psychogeriatrics Group is a working group of psychiatrists involved in psychiatric and mental healthcare and prevention services in the Madrid region of Spain, all of whom have a particular interest in psychogeriatrics. The group is made up of 18 psychiatrists who carry out clinical activities in the following urban and rural areas: 12 in outpatient Mental Health Centers, 5 in Hospital Services and one in Municipal Health Prevention and Promotion Services. This made it possible to cover a very broad spectrum of healthcare resources in the Madrid region.

Together, the members of the group decided to conduct fieldwork and share their experiences of psychogeriatric care during the first year of the COVID-19 pandemic. Although the working group operates independently, our results have been endorsed by the Spanish Psychogeriatrics Society (SEPG).

The information collected was divided into two sections:

- Problems detected in psychogeriatric care during the COVID-19 pandemic.
- Action taken to address these problems.

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The work was carried out in the following phases:

1. Gathering data. The participants collected information about their geographical area, healthcare setting and any other context accessible to them. The information was compiled in documents covering the two sections listed above.

2. Pooling information. A series of telematic meetings were held to discuss the information collected, evaluating similarities and differences. The group worked to reach a consensus on suitable solutions to the problems detected using a DELPHI-like procedure. A consensus on a particular topic was deemed to have been reached when more than 70% of the participants supported it.

3. Drawing up a table summarizing the problems detected and potential solutions (Table 1). The table was approved by all participants and forms the basis of this article.

RESULTS

The results of the consensus reached by the working group are summarized in Table 1. The table is divided into two sections. The first section details the healthcare problems identified and suggests solutions to address them. The second section sets out the main clinical problems detected and the solutions proposed to tackle them. In both sections, a. corresponds primarily to aspects relating to prevention, while b. and c. relate to intervention measures.

Table 1

	PROBLEM DETECTED	SUGGESTED SOLUTION
	A. FREQUENT PROBLEMS RELATING TO THE WAY IN WHICH HEALTHCARE IS DELIVERED	
1	Difficulties in accessing mental health services. Changes to the way in which care is delivered	- Implementation of telepsychiatry services
2	Difficulties in understanding and adhering to treatment regimens	- Provide as many in-person consultations as possible with strict safety protocols in place - Involve a relative in the telephone interview where necessary
3	Difficulties in referring patients from primary care to mental healthcare leading to reduced referrals	- Reinforce coordination with primary care centres to encourage referrals
4	Difficulties in contacting mental health professionals and services	- Facilitate contact and mechanisms for making appointments - Use of corporate email and e-consultation systems
5	Continuity of care	- Detect patients whose supervision has been interrupted due to the pandemic
6	Social and family isolation	- Micro-group activities in person - Groups via digital platforms
7	Care for patients in nursing homes and sheltered housing	- Teams for coordinating with nursing home/geriatric doctors - Assess the suitability of travel to in-person consultations at outpatient mental health centres - Consider the possibility of holding interviews via videoconference
8	Laboratory tests	- Computer tools to provide reminders of pending requests - Support from nurse

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	PROBLEM DETECTED	SUGGESTED SOLUTION
	B. FREQUENT PROBLEMS IDENTIFIED IN CLINICAL PRACTICE	
9	Bereavement support	a. Detection and early intervention to prevent the onset of pathological grief b. Individual interventions c. In-person or telematic group interventions
10	Sleeping problems	a. Provide education on sleep hygiene measures by telephone b. Suggest non-psychopharmacological measures to avoid over-prescription of hypnotic medications
11	Psychopharmacological treatments	a. Provide education on adherence to treatment regimens b. Review indication and duration of treatments c. Pay particular attention to certain medications, especially antipsychotics and anxiolytics/hypnotics, to ensure that temporary prescriptions do not become chronic
12	Physical deterioration	a. Encourage physical exercise at home b. Recommend healthy habits
13	Cognitive and behavioural deterioration	a. Recommend cognitive exercises at home and provide information about online material for cognitive stimulation b. Interventions with carers to manage cognitive and behavioural symptoms
14	Social deterioration	a. Detect at-risk patients through telephone interviews b. Recommendations to encourage social and family contact c. Facilitate contact with social and volunteer services
15	Violence	a. Actively explore the possibility of situations of conflict or violence b. Recommendations for handling difficult situations and encouraging positive treatment

Point a. corresponds primarily to prevention measures. Points b. and c. relate to intervention measures

CONCLUSIONS

At a time when in-person healthcare has been limited as much as possible, the priority in many places has been to ensure that consultations can continue safely. For this reason, telemedicine has been favored over in-person consultations. Efforts have been made to maintain in-person consultations in cases of decompensation, severe cases, cases where patients have difficulty understanding and following instructions given telematically, and initial consultations to strengthen the therapeutic bond. The number and proportion of face-to-face consultations has been increasing as the epidemiological situation has allowed it.

Telepsychiatry, which has become widely accepted and has proven effective in psychiatric care[11], has been one of the most widely used resources during the pandemic. It has taken the form of telephone calls and, to a much lesser extent, video calls.

However, subtle differences in body language, facial expressions and mild vocal inflections are harder to detect using digital technology[12]. Accessibility also represents a significant limitation to the use of these methods for providing healthcare. Elderly patients with a low income, lower level of education and poorer access to the internet, and who are less familiar with new technologies, may have less access to the necessary technology than others[3]. Fortunately, this is changing and we also see among the elderly the possibility of using social networks and other types of new technologies that would allow close contact and maintain communication in this way.

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It is essential that appointments for telephone or telematic consultations are respected. Many elderly people have felt abandoned due to the burden placed on healthcare institutions and they need to know that they will be contacted and when, so consultations must take place on the agreed date at the agreed time.

Despite the difficulties arising in their implementation, we believe that these technologies are here to stay[13]. However, the rollout of telepsychiatry has encountered barriers such as the digital gap affecting elderly people, sensory issues in psychogeriatric patients and cognitive deterioration in some patients[3,14]. Likewise, and given its novelty, so that telepsychiatry is carried out in the most efficient way possible, we also consider it convenient to train professionals in this work tool.

Support from relatives and carers, who have often accompanied patients during interviews, has facilitated access to technology. It has also enabled psychoeducation to be provided for relatives and carers, giving them a more comprehensive understanding of patients' conditions and tools for providing care (encouraging physical exercise, healthy habits, sleep hygiene, cognitive stimulation activities). Involving relatives and carers has probably improved adherence to treatment regimens and enhanced the detection and prevention of relapse and deterioration. Finally, it has also represented a source of emotional support for carers, as other authors have demonstrated[4].

Nevertheless, in some cases, the minimum standards of effectiveness and safety in telepsychiatry have not been met or it has not been possible to deliver the service at all. Therefore, in cases considered to be of sufficient clinical relevance, we recommend that in-person consultations are carried out with stringent safety measures in place to protect patients. Among these measures are the use of safe corridors and specific time slots reserved for elderly people. It is important to note that some elderly patients prefer to attend Health Centers in person if given the option, as they believe that their issues will be better understood and addressed than via telematic channels.

One of the main objectives throughout the pandemic has been to maintain continuity of care. Reductions in in-person consultations during the first wave of the pandemic and fear of visiting Health Centers, specialist doctors and hospitals among patients have given rise to reduced mental health demand and fewer check-ups and follow-up consultations. As patient referrals to specialists have declined, warning measures and coordination with primary care centres must be put in place to make it easier for patients to access specialist services. These measures could be the facilitation of contact and appointment control mechanisms, the use of corporate emails and e-consultation systems and, of course, reinforcing coordination programs between professionals.

Although the severity of this situation varies between patients, in some cases it has had a significant impact as chronic treatment which helped to stabilize the patient's pathology is interrupted or their treatment regimens are altered, increasing the risk of morbimortality. In addition to the efforts made by all healthcare services to implement and carry out telematic consultations to ensure continuity of care, lists of patients needing continuity of care should be drawn up to detect gaps in their supervision. In addition, it is recommended that information resources, telephone calls, mobile notifications, reminders of priority requests for analyses and diagnostic tests and reminders of appointments and referrals to specialists are put in place. Another problem relates to the difficulty of conducting routine tests and follow-up tests as part of treatment protocols involving lithium, valproic acid, clozapine and other psychotropic drugs. While the COVID-19 crisis continues, we recommend assessing the risks and benefits of patients attending Health Centers for tests on an individual basis to limit potential exposure to SARS-CoV-2.

In our view, nursing home residents should take priority, as the pandemic has had a greater impact on them than on others[15,16], and their care has been prioritized. The use of video and telephone calls to nursing homes, which have involved doctors and/or carers as well as patients, has been another very useful tool. This method has two benefits. On the one hand, it allows collegial interviews to take place with doctors from nursing homes acting as facilitators in the patient's telematic care. On the other hand it helps patients to understand basic concepts relating to illness and self-preservation, which elderly people can struggle with[17].

Throughout the pandemic, special consideration has been given to social isolation and loneliness. It is recommended that social isolation is specifically addressed in telephone interviews to facilitate detection. When cases are detected, attempts have been made to put patients in contact with social services and volunteer networks, while extra emphasis has been placed on psychoeducation for patients and relatives/carers during consultations and videocalls. Depending on the facilities available to them, it may be helpful for Mental Health Centers to organize telematic or in-person group activities with a small number of participants, offering support and information on psychoeducational and occupational themes.

Lockdowns have led to significant disruption to healthy habits. Elderly people in particular have experienced a

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dramatic reduction in physical activity. It is very important to encourage patients to carry out physical exercise at home: they should stand up and walk around every hour and perform stretching exercises once or twice a day. Support should also be provided to ensure that they have a healthy, balanced diet.

Geriatric patients have been shown to experience more disordered sleeping during the pandemic. This is most likely due to a worsening of existing psychopathologies such as depression or anxiety, as well as to insufficient activity. We believe that educating patients about healthy habits and sleep hygiene measures via telephone calls or videoconferences with healthcare professionals can play an important role in addressing these situations. This educational task must also involve finding non-pharmacological measures to avoid an increase in prescriptions of hypnotic medication, as has happened in many cases.

The pandemic has given rise to situations of high complexity and risk, such as bereavement. Bereavements have become more common for obvious reasons, with a concomitant rise in referrals for problems relating to grief[18]. Many people are often unable to rely on family and social support and may be prevented from performing the usual rituals to say goodbye to their loved ones, making it harder to grieve and increasing the risk of developing complicated grief. Bereaved patients were given special care, involving early detection and intervention provided telematically, either individually or in groups, with referrals from intensive care units and hospitals when these were deemed necessary by healthcare professionals.

During the pandemic, there has been a growing trend for higher doses of anti-psychotic and anxiolytic drugs to be prescribed. This has led to increased risk, given the difficulties in guaranteeing regular check-ups and conducting laboratory tests, electrocardiograms, etc[19]. Some authors have recommended avoiding starting or adjusting treatment regimens for behavioral changes or cognitive deterioration during this period[20]. In order to address the difficulties highlighted by several authors, we recommend paying closer attention to reviewing pharmacological treatment regimens to ensure that prescriptions issued during periods of flare-up do not become chronic. This frequently occurs with antipsychotics, as stated in the Document of the Spanish Society of Psychogeriatrics on the Use of Antipsychotics in the Elderly[21].

Particular attention should be paid to patients with cognitive deterioration. They require well-established, specialized interventions to ensure that they receive adequate clinical care[6]. During this time, closer attention has been paid to the difficulties involved in managing the behavioral changes associated with this deterioration. These behavioral changes may worsen as a result of factors relating to lockdowns, reduced care quality and increased morbidity from a range of causes[22]. A number of initiatives have been introduced to address these changes, including the use of tablets in nursing homes to help healthcare staff to manage BPSD and webinars to train nursing staff[123,24], and these options should be weighed up by doctors. Other working groups have suggested setting up 'hotlines' with an exclusive focus on treating these emergencies[25].

Another problem arising during this time is the increased risk of conflict in the home and elderly abuse. The vulnerability experienced by many elderly people who suffer from chronic illness or pluripathology or have some kind of disability due to mental illness, cognitive deterioration or mobility restriction makes them an easy target for abuse, ill-treatment and violence. This abuse is especially frequent among patients with sudden deteriorations in behavior[3]. The pandemic could increase the risk of abuse, neglect and distress among elderly people in general[26] and with dementia in particular[27].

It is important to differentiate between accidental violence, acknowledged by the carer as the product of overwhelm, and instrumental violence intended to harm others. In the case of accidental violence, carers have a problem that affects the patient and leads to dysfunctional interactions; carers should act as a source of psychological, social and pharmacological support to minimise the risk of unintended violence. In the case of instrumental violence, the motivation is criminal and the methods required to address it are more complex, exceeding the scope of clinical care and moving into legal territory. Intervention should ensure that the victim is not harmed rather than assisting the abuser, although the assessment of the situation may not always be shared or accepted by victims, who are not necessarily incompetent.

In order to address the issue of violence, this aspect should be actively explored during consultations, applying geriatric models for identifying the presence of violence due to overwhelm with help for relatives, or addressing the problem with support for vulnerable patients. For this purpose, the use of tools (questionnaires or key questions) may be helpful. A comprehensive review[28] describes different instruments that can be used in clinical practice to evaluate elderly abuse. Providing relatives/carers with recommendations for handling behavioral changes, especially in patients with dementia, is another method used to prevent abuse. Other groups have suggested that identifying and creating environmental support mechanisms that give elderly people a strong sense of community should be a priority in social policy. This social support provides protection against abuse and neglect[29].

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In conclusion, the challenges facing psychogeriatric services during the pandemic have required the introduction of new measures and the intensification of existing ones.

In our experience, telepsychiatry has contributed to more efficient management during this period by improving access to care for patients and communication with carers, enhancing coordination with other healthcare professionals and facilitating appointment management, as well as allowing psychoeducational and therapeutic material and care resources to be exchanged, situations of risk to be detected and psychotropic treatments to be monitored. These conclusions are echoed by other authors[30]. However, these activities are not without problems, as this work tries to show. Many of the difficulties relating to their implementation could be circumvented by developing these technologies to make them easier to use and more accessible for elderly people and those who care for them[31].

It is important to emphasize that our support for telepsychiatry in the midst of a pandemic with a highly contagious virus owes to the fact that it is a sensible option in times of danger. Once the pandemic or the period of highest morbimortality are over, our view is that in-person interviews remain the gold standard of psychogeriatric care, although telepsychiatry will certainly have a place. The lessons learned from the use of telepsychiatry during the pandemic and the absence of significant problems in the short term force us to consider the use of the method in the post-pandemic era in certain contexts and clinical situations where there are clear barriers to in-person care for elderly people. We believe that it would be useful to draw up a scale or checklist of the potential risks and benefits of the use of telemedicine in all its forms (telephone, videoconferences, email) in different circumstances affecting elderly people (great distance from healthcare centre, institutionalisation, severe mobility difficulties, etc.).

Given the difficulties and peculiarities of psychogeriatric care, it certainly is necessary to adopt specific action plans to prevent and treat mental health problems in this population. In this context, we felt it important to report our observations so that they may be used by other professionals who are active in this field, as well as to avoid repeating shortcomings in patient care and support in the event of future waves of COVID-19 or other pandemics, as other authors have suggested previously[18]. The conclusions that we are presenting here are the fruit of a Spanish working group, endorsed by the Spanish Psychogeriatric Association, but we sincerely believe that they can be extrapolated to different health systems in other countries and be of benefit to them in the fight against the current pandemic or in other similar situations.

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Conflict of Interest

None.

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