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CANADIAN ACADEMY OF GERIATRIC PSYCHIATRY | ACADÉMIE CANADIENNE DE GÉRONTOPSYCHIATRIE

Canadian Coalition for Seniors' Mental Health
Coalition Canadienne pour la Santé Mentale des Personnes Âgées

Mental Health Care in Long-Term Care During COVID-19

Position Paper

KEY POINTS:

1. Mental health care is an essential medical service that must be maintained during any pandemic.
2. Older adults living in LTC facilities have the right to mental health, medical care and social services, regardless of their age, the presence of dementia, or a diagnosis of other mental health problems and illnesses.
3. LTC facilities must be provided with the technology and resources necessary for provision of essential virtual medical services and for the maintenance of family and social connections when in person visits are restricted.
4. Infection control measures intended to reduce the spread of infectious diseases must also balance the impact of these measures on the quality of life and dignity of LTC residents.
5. Supporting the mental health of LTC staff is critical to effectively managing pandemics in LTC.

INTRODUCTION:

One of the many tragedies of the COVID-19 pandemic has been the significant mortality and psychosocial consequences disproportionately experienced by older persons, particularly those living in long-term care (LTC) facilities. Throughout the pandemic, Canada has consistently had one of the highest global proportion of all COVID-19 deaths occurring among LTC residents.[1-3] While many recommendations related to improving care for LTC residents during COVID-19 have been created both nationally[4-8] and internationally[9,10], none have focussed on the mental health implications associated with COVID-19 in LTC. Mental health disorders including dementia, depression, and anxiety[11,12] are more prevalent in LTC settings than among older adults living in the community. Despite this high need for mental health supports among LTC residents, their access to mental health care was poor even prior to the pandemic[13,14].

Several factors have contributed to a potential worsening of the mental health of LTC residents during COVID-19. Ageism[15], predating COVID-19, is contributing to the adverse mental health

impacts related to COVID-19 in LTC in Canada. Older adults with mental illness and dementia are particularly susceptible to negative consequences of ageism[16,17]. The COVID-19 pandemic has identified long-standing consequences of ageism in LTC due in part to measures implemented to manage COVID-19 in this setting[9,18]. Furthermore, longstanding staff shortages, limited staff education about dementia and mental health, and poor access to medical and psychiatric specialized services in LTC have all contributed to the current crisis in LTC[19]. While this serious problem has received media attention[20], these concerns have not been reflected adequately in recommendations meant to address and mitigate the impact of COVID-19 in LTC. Already concerns have arisen that quality of care in LTC facilities has deteriorated further with reports of increased use of antipsychotics and restraints to managed increased occurrence of behavioural symptoms of people with dementia in LTC or to prevent LTC residents from wandering within LTC facilities to potentially prevent the spread of COVID-19[21]. This position paper highlights the mental health care needs of older persons living in LTC settings during COVID-19 and other similar pandemics.

METHODS:

The Canadian Academy of Geriatric Psychiatry (CAGP) and Canadian Coalition for Seniors Mental Health (CCMSH) established a working group to develop a position statement on mental health care for older adults in long-term care settings. A call for expressions of interest to participate in the working group was distributed to current CAGP members. A working group planning committee initially met in July, 2020 to identify the scope and anticipated outputs for this project. The final working group consists of 14 individuals (Appendix A) representing geriatric psychiatrists and geriatric psychiatry trainees from different provinces, care settings and career stages. The working group met by videoconference a total of 4 times to prepare the position statement. The working group drafted position statements and working group members contributed to reviewing the evidence related to each position statement. The final position statements and accompanying evidence were arrived at by consensus.

POSITION STATEMENTS:

Statement 1: Mental health care in LTC settings is an essential service.

While access to medical services may need to be adapted during COVID-19 and other outbreaks in keeping with public health requirements, mental health care in LTC settings is an essential service. This includes access to outpatient, outreach, inpatient and specialized mental health treatments such as electroconvulsive therapy (ECT), within the limits of necessary infection control practices.

During the initial outbreak of COVID-19 in Canada, preparations for an anticipated influx of COVID-19 patients into acute care led to the cancellation of many medical services and surgical procedures that were deemed non-essential at the time. In addition, many hospital-based outpatient programs and procedures such as ECT were suspended or severely curtailed to prevent introduction of the virus[22]. Medical services provided directly in LTC were also reduced to those deemed essential. As a result, many individuals with mental health conditions

in LTC settings had mental health assessments or treatments delayed or cancelled during the first six months of the COVID pandemic in Canada.

While mental health assessments or treatments can be delayed for some individuals on a short-term basis due to necessary infection control practices, many individuals with mental problems and illnesses in LTC facilities do require urgent access to ongoing, consistent and reliable mental health services. These services may include outpatient visits, outreach services, inpatient admission, and the ability to initiate or continue hospital-based mental health treatments such as ECT[23]. COVID-19 has disrupted mental health services in most countries[24]. While COVID-related restrictions to health care provider visits have disrupted mental health services in most LTC facilities, the impact of COVID-19 on access to mental health services in LTCFs is currently unknown. Therefore, health systems need to provide the necessary safeguards and processes to allow ongoing mental health care for older adults in LTC while at the same time protecting long-term care residents and the community from the very real risks associated with COVID-19 infections.

Statement 2: Factors such as age, the presence of dementia, or a diagnosis of mental health problems or illnesses are not reasons to exclude individuals from having access to resources such as emergency departments or inpatient hospitalization.

The COVID-19 pandemic has challenged healthcare organizations to prepare for increased demands on acute care. Crisis triage protocols have been developed, but often use survivability to determine allocation of health care resources[25]. This approach may stigmatize older adults, and those with chronic illness or disability[26]. Older adults who contract COVID-19 have higher mortality rates, especially in the presence of chronic medical conditions[26]. Long-term care (LTC) residents have a high burden of such illnesses and the presence of frailty and dementia further compounds their vulnerability[27,28].

On admission to LTC, advanced care planning and goals of care discussions should occur between individuals and/or their substitute decision makers (SDMs) and health-care teams. Furthermore, these discussions should be routinely revisited[29]. Individuals and/or SDMs should be provided the best information to make informed choices about whether or not to remain in the LTC setting or be transferred to an acute care setting for treatment and about the level of care that is to be received. Individuals and their families must be supported through this process and be able to express their wishes, while also being made aware of the significantly lowered survival rates among older adults with a high burden of medical illness and frailty who become infected with COVID-19. The presence or absence of cognitive impairment should not in itself preclude access to treatment but should factor into decisions about goals of care. It is essential that stigma, presumed decreased quality of life, and ageism do not influence these decisions.

Statement 3: Restrictions on in-person visits to LTC must consider the potential effects of these restrictions on the mental health, quality of life, and dignity of LTC residents and their families.

While some restrictions on LTC visits will be required during infectious disease outbreaks, the least restrictive approaches to visitation permitted during pandemics should be made available to all LTC residents**.** Restrictions intended to prevent the spread of COVID-19 have significant impacts on the social networks of individuals and plans to minimize potential negative impacts of social isolation need to be considered in conjunction with any restrictions to visits in LTC.

Plans to minimize the negative impacts of isolation on these individuals and their families should be in place, including adherence to compassionate practices for ensuring social connection and care[30]. This should include offering at least weekly contact with a family member through virtual means or a safe in-person visit with appropriate personal protective equipment. Ideally, patients would be able to receive visits in accordance with their needs and not be limited to an arbitrary number. Most effective non-pharmacological interventions for dementia in LTC facilities, including one-to-one visits provided by family members or other individuals, require 2 to 3 interactions per week for sustained benefits on mood and behaviors to be observed between interactions[31]. Specific plans for all infectious outbreaks in LTC need to include not only infection prevention measures, but also a plan to maintain nursing care, social contact, and activities that support the mental health of the residents and prevention of unnecessary physical and cognitive decline. While these measures are often implemented during infectious disease outbreak in LTC facilities, during COVID-19 these restrictions occurred for prolonged periods of time and had significant impacts for the residents of LTC. These included loneliness, anxiety, feelings of insecurity, suicidal thoughts as well as physical and cognitive decline[13].

Caregivers have also experienced significant stress when they could no longer be physically present to support their family members in LTC facilities. This was compounded in many situations by a lack of information and communication from LTC facilities about their loved ones. LTC facilities should implement processes to provide LTC residents, their families and caregivers, and staff with timely information related to the COVID-19. LTC facilities may consider providing access to electronic charts or secure communications for family members. All LTC facilities should have LTC staff who are key contacts and can provide timely information to LTC residents, their families and caregivers.

Statement 4: **Appropriate communication technology and human resources must be available to allow communication between LTC residents and individuals located outside a resident's LTC facility.**

Access to virtual communication technology (e.g. phone, tablet, or computer-based videoconferencing) has been identified as critical to ensuring that LTC residents are able to communicate with families, friends, and health service providers who are unable to visit an

individual in person at a LTC[32,33]. Utilization of telemedicine (services delivered by physicians) and telehealth services (delivered by other health care providers) have been identified as key to maintaining access to health care during COVID-19[34] to and reducing disease transmission[35]. Older adults in LTC facilities may suffer the effects of "double burden of exclusion" by having restrictions to in-person visits and limited access to technology needed for other methods of communication[36]. Unfortunately, many LTC facilities have limited access to the technology, expertise and human resources necessary to support this form of communication at all or as frequently as would be optimal for an individual's needs.[33]

Each LTC facility should have the infrastructure to support virtual visits with family and health care professionals. At a minimum, this should include high-speed internet connection, and the provision of portable devices (e.g. tablets or laptops) for LTC residents who does not have access to their own personal device. All LTC staff should have basic knowledge of facilitating visits with families using commonly used platforms. The unique needs of older adults with dementia, mental illnesses, and co-morbid sensory impairments must be accommodated in these visits. Each LTC facility should have two or more staff per resident care unit trained in facilitating secure and private virtual health care visits that follow required privacy regulations. Interprofessional teams based outside of LTC facilities should also receive training in conducting virtual assessments and be provided with the virtual technology necessary to complete assessments.

Statement 5*:* Public health measures limiting access to in-person visits, restrictions of movement within LTC facilities, and cessation of LTC social programming must consider the risks and benefits to specific individuals in LTCs.

LTC facilities did not allow any visitors in the early stages of the COVID-19 pandemic, which resulted in an overwhelming response from LTC residents, their families and caregivers about the negative impact of these restrictions[37]. Early studies examining the reintroduction of visitors in LTC through carefully implemented policies, have demonstrated success and show that these visits have not led to a significant increase in the rates of COVID-19 infection[38]. There are emerging recommendations on the re-integration of family caregivers into LTC, which require rapid dissemination to adopt evidence-based visitation policies that provide a better balance of infection control measures with quality of life[39].

Failure to utilize family presence in LTC facilities to support older adults exacerbates the current gaps in the LTC workforce. It is estimated that approximately 750,000 Canadians provide care to a family member in a LTC setting with over 20% of them providing over 10 hours per week of care including personal care[40]. LTC residents have discussed their experiences over the last six months with some describing their experience as "devastating, emotional, terror awakened, muzzled, trapped, broken-spirited and boredom"[37]. Research into the impact of these restrictions in LTC facilities should include direct interviews with residents and family caregivers[37].

As new policies for the integration of family caregivers at LTC facilities are developed, they should follow a person-centered approach. Processes must be in place for exceptional circumstances where family caregivers are required as part of an individual's mental health care plan. Geriatric psychiatrists and LTC mental health service providers should be consulted in the development of these policies and be included in the review of such exceptional circumstances.

Statement 6: **All LTC facilities must have adequate training, staffing and resources to assess and treat common mental health conditions during COVID-19 and other infectious disease outbreaks.**

While mental health conditions are common in LTC settings[11], access to mental health and psychiatric services in LTC is limited[14]. Canada has shortage of geriatric psychiatrists which is unlikely to improve substantially in coming years[41]. Research has suggested that COVID-19 has resulted in an increase in behavioural symptoms of dementia in LTC resulting in an even greater need for mental health care[42,43]. It is therefore important that all LTC facilities have adequately trained staff and sufficient resources to assess and treat common mental health conditions, during COVID-19 and similar periods of infectious disease outbreaks when access to mental health resources is even more limited.

Staff training approaches are among the best supported interventions for addressing behavioural symptoms of dementia in LTC settings[31]. Guidelines recommend that all LTC facilities provide staff with training in the assessment and management of common mental health disorders[44,45] such as delirium and depression[44], management of neuropsychiatric symptoms, and responding to emergent mental health crises[46]. These training programs require access to trainers (often associated with geriatric mental health programs) as well as resources to allow staff to attend these courses as part of their paid employment while ensuring an adequate number of staff are available to support the ongoing needs of LTC residents. Some LTC homes may have mental health champions or embedded mental health resources provided by either the LTC facility or through partnerships with provincial mental health programs. Mental health care provided by LTC staff can be supplemented by regional outreach programs or telemedicine[47].

Statement 7: **Governments, LTC, and mental health service providers must ensure that staff working in LTC during the COVID-19 pandemic have adequate access to mental health supports and programs to support staff wellness.**

Staff working in LTC settings were experiencing significant stress and devaluation due to chronic understaffing of LTC facilities prior to COVID-19. COVID-19 has contributed additional stressors related to a worsening of staffing shortages, initial shortages of PPE and ongoing risks of staff contracting COVID-19 and the high death rates in COVID-19 affected facilities[48,49]. Each individual may respond to the new stressors associated with COVID-19 differently[50]. To mitigate these negative sequelae, LTC facilities must promote and maintain the mental health and wellbeing of frontline staff by ensuring measures are taken to adequately support staff and

ensure their safety and recognize the value of their work[49]. This includes access to appropriate personal protective equipment, and educational programs to ensure its proper use[5]. Psychoeducation on caregiver burnout, stress management, anxiety and depressive disorders should be incorporated in job training at long-term care facilities, and regularly reviewed to promote staff resilience. Sick leave and employee assistance programs should be made available to staff working in facilities impacted by COVID-19. Other recommendations related to supporting LTC staff have included clear guidance from LTC facility leadership, optimizing human health resource planning, and adoption of clinical practices to minimize the impact of COVID-19 in LTC[49].

Statement 8: Measures of mental health and quality of life in LTC facilities must be systematically evaluated during COVID-19, and strategies implemented to understand and remediate adverse mental health outcomes when they are identified.

Mental health and quality of life must be systematically evaluated to assess the effects of the COVID-19 pandemic on LTC residents. This monitoring will help identify early signs of worsening of mental health symptoms within individual LTC residents and facilities and identify individuals and facilities which may require additional supports or resources, similar to how LTC with COVID-19 outbreaks are currently triaged for additional supports based on their needs.

While mortality and infection rates may reflect the most important measures for monitoring of the impact of COVID-19 in other settings, they capture only part of the effects of COVID-19 in LTC. One of the most dramatic effects of COVID-19 in LTCs has been the increase in social isolation of residents due to restrictions on visitors and residents' ability to leave their care home. Social isolation has adverse mental health outcomes such as worsening of depression, cognitive decline and behavioural symptoms of dementia.[51]

Measurement is the basis of monitoring quality of care, overall health status, and identifies opportunities for improving quality of care amidst the COVID-19 pandemic. Monitoring quality of life, functioning, and mental health can be done without creating new or onerous data collection. For example, the Minimum Dataset Resident Assessment Instrument (MDS-RAI) is a routine measure used in many LTC facilities, which includes quality indicators measuring depression[52], behavioural symptoms[53], and cognition[54]. Incorporating these and other relevant measures of long-term care resident health status as part of COVID-19 related outcomes would provide a more accurate picture of the effects of COVID-19 in long term care.

CONCLUSION

All Canadians have been affected by the COVID-19 pandemic and none more so than LTC residents. As LTC residents, their families and those caring for them continue to be affected by the COVID-19 epidemic we anticipate that the mental health of LTC residents, their families and LTC staff will continue to be significantly impacted. Our position statements provide actionable strategies and priorities to minimize the impact of COVID-19 on the mental health of individuals

in LTC. Collectively we can learn from our actions in the past and make plans for a future that better meet the mental needs of individuals in LTC during COVID-19.

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Appendix A

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