

Special Issue: Telehealth & Mental Healthcare of Older Adults

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Editor's Note

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The COVID-19 pandemic has been unexpected and created many problems and challenges in healthcare. Mental healthcare, especially old age mental healthcare, is no exception. For example, many long-term care facilities were closed due to the COVID-19 pandemic, and relatives were not allowed to visit their loved ones residing in these facilities. In response to the regulations of physical distancing to prevent COVID-19 transmission, telehealth has been increasingly adopted. Typical applications include telehealth in outpatient service, inpatient care, virtual visits for nursing home

residents, and teleconference, etc. Besides, technology-enabled social and recreational programming has been adopted, specifically in the field of old age psychiatry. Because of the persistence and impact of this pandemic, telehealth will undoubtedly be used more widely in old age mental health in the future. In this special issue of the *IPA Bulletin*, we have a total of eight articles from around the globe sharing different experiences and visions on telehealth in old age mental healthcare. These articles provide unique viewpoints and perspectives from a variety of regions of the world and deserve our IPA members' attention during the current difficult time in facing the pandemic.

Although telehealth may emerge as a new kind of care method, there are several problems and challenges in most regions of the world, including but not limited to the following issues:

1. Laws and regulations on telehealth may be inadequate, including the scope of telehealth, practice standards, personnel certification, data security, and reimbursement, etc. ^[1]
2. Special applications such as capacity assessment should be addressed clearly if possible (see the article of Sorinmade et al. in this issue).
3. Telehealth hardware may be hard to use for older adults. The devices should be tailored to serve the needs of older adults, especially patients with dementia. Ideally, the devices have to be not only user friendly but also with adequate aids for sensory impairments common in this target population. Good connection quality is also crucial since it is challenging to integrate unsynchronized information resulting from a connection lag.
4. Though telehealth has become a necessary component in healthcare nowadays, we should systemically examine its efficacy, practicality, and cost-effectiveness. The pros and cons of different telehealth models, either in a naturalistic way or through a well-designed experiment, should be investigated. ^[2]

residents were unable to leave the facility for reasons other than a medical emergency requiring hospitalization. Access to routine medical surveillance and follow-up care became challenging as ambulatory clinics were closed down in all surrounding hospitals. Physicians, who supported several care homes, were increasingly reluctant to potentially introduce the virus across multiple facilities. While these measures mitigated the risk of viral outbreaks, there has been a large cost: social isolation of the resident population and interrupted access to healthcare services.

Baycrest, headquartered in Toronto, Canada, is an academic health and residential care organization that operates 1,100 beds across a full continuum which includes a rehabilitation and chronic care hospital, a retirement residence, a nursing home (long-term care facility), and apartments for independent older adults. Our organization also has a full array of ambulatory medical clinics, day programs, and home-based virtual and direct care programs. We are home to some of the most comprehensive research, innovation, and educational activities housed in a seniors care setting.

In February 2020, Baycrest established a number of teams to prepare for the emerging pandemic's potential impact on our community. We needed to procure adequate amounts of personal protective equipment, ensure thorough screening of all persons entering our facilities, enhance our emergency preparedness and IPAC policies and procedures, and greatly amplify the scope of our virtual healthcare and related technological capacities. On this last consideration, we focused on lessening the impact of the pandemic on anticipated reductions in face-to-face client visits with physicians, cessation of family visits, and suspension of all group recreational and social activities.

In mid-March 2020, Baycrest's Telemedicine Rapid Implementation (TRIM) Team was created. Its mission was to rapidly develop and deploy telemedicine and virtual care capabilities across all Baycrest campus care settings and into the surrounding Toronto community to serve our isolated hospital outpatients and home-based clients. TRIM membership was multi-disciplinary and included clinicians, educators, technologists, recreational therapists, innovation leaders, operations specialists, and project managers. Members of the TRIM group set aside many of their regular duties and rallied around designated team-leaders to collaboratively work on three main areas of need: telehealth, virtual visits for nursing home residents with their family members, and technology-enabled social and recreational programming.

Telehealth/Virtual Family Visits/Social and Recreational Programs

Baycrest clinicians have had a long-standing telemedicine and tele-psychiatry service using secure videoconferencing technologies to care for patients in remote rural communities outside of Toronto. With the coming of the pandemic, the care model had to be adjusted. Physicians located off-campus would have to remotely care for on-campus hospital patients and the residents of our nursing and retirement homes. To rapidly implement this capability, the TRIM team developed and deployed telemedicine equipment, clinical workflows, staff training, scheduling tools and supports. We assembled more than 50 low-cost telemedicine 'T-Carts' from off-the-shelf components such as mobile stands, iPads running secure videoconferencing



software and telemedicine specific apps, a digital stethoscope, amplified speaker/microphone and headsets, a unified USB charging hub, and a laminated one-page “quick-start guide” affixed to the cart. Simultaneously, we greatly expanded our use of telemedicine to bring ambulatory healthcare services to our clients living in the surrounding Toronto community. We augmented our community-outreach teams with virtual care equipment and centralized supports. We provided virtual behavioral support consultation to 36 nursing homes in the surrounding area. Outpatient geriatric psychiatry services became completely virtual, including group therapy. Additionally, we deployed our T-Carts to nine seniors’ apartment buildings in the city to offer them remote healthcare support. Staff from different parts of Baycrest, who had experience working with our clients, played a key role in supporting all of this functionality, including the conduct of virtual family visits and technology-enabled social and recreational programs. Through this work, more than 6,000 video and/or audio telemedicine encounters were enabled from mid-March to the end of June, 2020. One important success factor was the provincial government’s approval for physicians to be reimbursed for greatly expanded virtual care visits.

Along with implementing many more virtual healthcare services, a significant challenge was to enable our clients to visit with their families. In-person visits to our residential facilities and our hospital were prohibited by government mandate to control the spread of the virus. We virtualized family visits by employing telephone and videoconferencing technology to create a scalable ‘eVisit’ service. eVisits were scheduled by clients or families through our Virtual Care Resource Centre. Staff brought the devices to our clients in their rooms and assisted them in connecting with their remote family members. Over 5,000 eVisits were supported from mid-March to the end of June 2020.

The third area of focus for the TRIM team was addressing the sudden cessation of group recreational activities brought on by the need to keep clients and staff physically separate. Both internal and external recreationists were teamed with on-line media specialists to digitize and adapt a broad range of Baycrest programming. We rapidly developed engaging brain and body health content that could be delivered digitally to our clients in their rooms. Programming appeared in weekly calendars detailing dozens of internally developed and externally sourced on-line exercise classes, creative arts, museum tours, book clubs, storytelling, music appreciation, and religious events. Live programming was offered at given times during the day, as well as on-demand content that could be accessed at any time. These programs were delivered through the provision of hundreds of smart TVs and iPads. ‘Baycrest TV’, a newly created, dedicated cable channel was made available in all client rooms.

Importantly, the pandemic pushed Baycrest to much more rapidly implement technology-supported enhancements to the health and overall wellbeing of our older adult clients than would have otherwise occurred.



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Video-conferencing with older people with mental health problems: reflections on risks and safeguards

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The COVID-19 pandemic has resulted in a rapid and unprecedented change in how services are delivered in the United Kingdom (UK). One of the changes it has precipitated is a shift to remote working, with face-to-face encounters between patients and healthcare practitioners limited to essential and unavoidable circumstances. The General Medical Council published guidance and a flowchart to help medical practitioners decide when it is appropriate and safe to treat patients remotely¹. There are issues of particular concern when working with older people and with those older people who have mental health problems and, as old age psychiatrists, we have had to try to connect with people differently over the past four months. Whilst video consultations have potential advantages in this pandemic period (and in future), they also pose significant ethical considerations for healthcare services, practitioners, patients and carers.

Our experiences

Between us, we have experience of systemic therapy and supervision online, carrying out second opinions under mental health legislation and remote video hearings as a Mental Health Tribunal doctor: but who would have imagined that memory clinics could be carried out remotely? Yet earlier this year one of us carried out her first remote primary care memory clinic, involving telephone and online video-conferencing consultations with follow up and new patients. It went surprisingly well.

¹ [https://www.gmc-uk.org/-/media/gmc-site-images/ethical-guidance/learning-materials/themes/remote-consultations-diagram-april-2020-\(002\).svg?la=en&hash=3BFAD4683392DABF0E512E931617952CDAC385C4](https://www.gmc-uk.org/-/media/gmc-site-images/ethical-guidance/learning-materials/themes/remote-consultations-diagram-april-2020-(002).svg?la=en&hash=3BFAD4683392DABF0E512E931617952CDAC385C4)

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Thus, the COVID pandemic has highlighted the importance of video consultations between clinicians in different settings, and also between clinicians and patients in their own homes, for routine reviews as well as new assessments. For routine reviews, video consultations have been relatively easy, as the patient may be well known to the clinician, but new assessments are more difficult, especially in cases where risks may be high and are only elicited after starting the video consultation: sometimes consultations have had to be aborted in favour of face-to-face assessment.

Balancing the pros and cons

Reading about remote consultations, the literature supports some of our main concerns, including:

- Digital and language exclusion – are older adults less likely to be acquainted with the devices needed for video-conferencing and, even if assisted by family members, to find the experience of using them anxiety-provoking or daunting? Against this, we know that older adults are increasingly using devices for a variety of purposes, so this may be less of a problem than one might anticipate. And what about exclusion by virtue of language – how would we carry out a remote consultation with someone who speaks no English or requires an interpreter?
- Technical difficulties – we may need to plan ahead for poor connections and contingencies should the connection fail. Sometimes the connection can lag behind and audio or video is delayed or unsynchronized: how might this affect an older adult with sensory difficulties and/ or cognitive issues?
- Risk and safeguarding – how to assess risks online, recognising that risks in older adults may be different from those in younger people. On screen, how do we see whether there is food in the kitchen and detect signs of self-neglect? How do we identify people where there are safeguarding issues?
- Carer issues – Whilst acknowledging that the vast majority of carers have their relative's best interests at heart, sometimes it may be difficult to know how someone is potentially being influenced by others when seeing them online and, if the other person is asked to leave, can we be sure they have left the room and are not continuing to influence the conversation?
- Capacity and consent – Does this person understand that this online contact, bizarre as it might seem, is, for example, a memory clinic and that the person talking to them is a doctor carrying out an assessment?
- New assessments – are there particular concerns about new assessments? With older adults there may be additional challenges in engaging and developing a therapeutic relationship remotely, particularly if someone has sensory impairments.
- Body language – we lose the information that comes from body language. This might be particularly tricky when someone's first language is not English or perhaps when they have some form of

speech difficulty. In addition, digital platforms may compress video, so that facial expressions are hard to interpret². This might be very risky during mental health assessments and mental state examinations, as it is imperative to be able to assess the appearance and behaviours of the patient/relatives.

- Sensory impairments – may complicate remote consultations. Hearing impairment may make communication online difficult, and visual impairment may make lip reading difficult although tech-savvy people might enlarge someone's face onscreen to make lip-reading easier (and certainly easier than when talking with someone wearing a face-mask).
- Therapeutic relationship - Some issues may be better discussed face to face. Is the challenge implicit in sharing a diagnosis or working out an advance care plan exacerbated by difficulties in establishing a therapeutic relationship and demonstrating empathy in virtual consultations? However, against this, during the pandemic, these issues have had to be addressed remotely and sensitively.
- Power – does remote consultation privilege clinician power over the autonomy and power of patient and family? How might this influence shared decision-making?
- Costs - some evidence suggests that telepsychiatry would be expensive for healthcare organisations initially due to necessary investments in infrastructure etc., but over time money may be saved (e.g., in relation to travel and other overheads, and due to savings in clinicians' time): yet what about the costs to patients and carers who will also need appropriate technologies and the confidence to use them?

Alongside this, remote consultations offer advantages to healthcare practitioners, patients, and family (and perhaps society):

- No time needed to travel for clinicians and families. Sometimes family members need to devote a lot of time and effort to getting their relatives out of the house and to the clinic. How much easier it is to be seen at home.
- In the midst of a pandemic, risks to all concerned are considerably less as contact with others is kept to a minimum or completely abolished.
- Care Homes, in particular, may appreciate remote consultations for the above reason, and patients, family, and practitioners may all connect simultaneously should that be appropriate and should all concerned consent to do so.
- Patients and family members may be more relaxed in their own environment: attending a clinic, even in primary care, may be a source of anxiety.

Conclusions

Tele-psychiatry is an option in some areas of mental health because the nature of the specialty involves gathering information from audiovisual assessments, and it is possible to provide diagnosis and treatment

² Greenhalgh T, Vijayaraghavan S, Wherton J, et al. *BMJ Open* 6:e009388, 2016.

Questions were formulated based on the technology acceptance model 2 (TAM2) and based on questionnaires examining the use of similar technologies in nursing homes²⁻⁵. It consisted of four main topics: (1) the perceived use of video call technology; (2) the role of nursing homes in assisting with the use of video call technology; (3) personal outcomes related to the use of video call technology; (4) future use of video call technology. Besides multiple choice questions, the questionnaire consisted questions using a 5-point Likert-scale.



Moreover, two open-ended questions were asked:

- (1) Did the use of video calling lead to any other positive effects?
And if so, which effects?
- (2) Did the use of video calling lead to any other negative effects?
And if so, which effects?

The multiple choice questions (%) and mean ratings were analysed using descriptive statistics. Compound scores were computed for statements related to the same topic. The answers to the open-ended questions were analysed using open and axial coding.

Findings

- Overall, 64 persons (78.1% female) filled in the questionnaire.
- The mean age of participants was 52.8 years (SD 14.0); for nursing home residents, the mean age was 79.6 years (SD 13.36).
- The majority of participants had a parent living in a nursing home (53.1%); the majority of relatives of participants had a form of dementia (82.8%).
- Almost all participants (93.8%) already had the technology they used themselves; 70.3% of nursing home relatives received the technology from the nursing home.
- Whatsapp was used by 51.6% of participants, followed by Skype (31.8%) and FaceTime (28.1%).
- Some participants used multiple technologies.
- In total, 85.9% of participants indicated that their relative received help from the nursing home during video calling.

Table 1 shows the mean ratings of the statements, arranged per topic. Ratings with a min-max score other than 1-5 are compound scores. Higher scores are reflective of agreements, whereas lower scores reflect disagreement. As can be seen, participants overall agreed with the technology being easy to use. Another rating that stood out was the support received from the nursing home, which can be considered quite low.

The analysis of the first open-ended question showed one major theme: the ability to be able to see each other while talking (*see table 2 below*). The answers provided to the second open-ended question identified seven themes:

(1) relative not understanding video call technology, (2) emotional burden on participants, (3) missing physical contact, (4) deteriorating health status of relative (5) lack of privacy and (6) lack of support from the nursing home. While the ability to see each other was mentioned to be a positive aspect, for many the use also yielded negative effects. These included being confronted with the deteriorated health of the relative or seeing them cry. During the video call, many felt the need to comfort their relative by physically being with them, but were frustrated this was not possible.

The majority of participants did not report the support of the nursing home to be lacking. However, other participants mentioned they only were offered the ability to video call with their relative after a few weeks, which in their view was too late. In addition, in some cases the negative consequence of proper support

Table 1. Mean ratings of statements (topic 1, 2, 3 & 4)

Ratings	Mean (SD)	Min - max score possible
<i>Topic 1</i>		
Ease of use	12.47 (2.63)	3-5
Recommending others to also use video call technology*	3.38 (1.35)	1-5
Rather using video call technology than phone call or text*	2.88 (1.25)	1-5
Finding video calling a good alternative to meeting physically*	2.95 (1.39)	1-5
<i>Topic 2</i>		
Support received from nursing home	12.23 (3.45)	4-20
<i>Topic 3</i>		
Helps decreasing loneliness	4.84 (2.04)	2-10
Has additional value over text and phone call	5.92 (2.38)	2-10
Improved wellbeing of participant	2.94 (1.25)	1-5
Improved wellbeing of relative	3.13 (1.37)	1-5
<i>Topic 4</i>		
More support in the future	5.69 (1.89)	2-10
More open to use video call technology than before	2.53 (1.23)	1-5
Keep on using video call technology after pandemic	2.48 (1.31)	1-5

*note: for as long as meeting physically is not possible

from the nursing home during the video call seemed to be the lack of privacy caused by the fact that the nurse had to be present during the call.

Discussion

Overall, the study showed mixed results, with video call technology being more helpful for some than for others. The result of the current study also demonstrates that the cognitive ability of the relative is an important factor. Some participants reported that their relatives were unable to understand the technology due to a form of dementia. This is underscored by previous studies showing that this kind of technology isn't a 'one size fits all' ^{6,7}. Part of the unpleasant experiences of participants could also be explained by the insufficient support of the nursing home, as some participants described how the lack of support from the nursing home caused problems. Sometimes the ability to use video calling came too late (i.e. weeks after the nursing homes were closed) which led to frustration. In addition, participants reported unsolid internet connections and nurses "being digitally illiterate". Hence, to ensure better experiences, nursing homes could ensure that their staff has the digital training needed for this type of communication and could invest in IT support. This latter option might also increase the speed with which the video call technology is introduced especially in the case of future pandemic-related restrictions. By doing so, video calling might not be a substitute for face-to-face visits, but might be a more gratifying practice.

This study had a small sample size, including participants who were already active online (and thus might already be savvy with technology). Consequently, our results should be generalized with caution. Qualitative studies could be conducted to provide more in-depth insights into experiences regarding video call technology and the support of the nursing home. These could then also focus on how relatives view other alternatives to physical contact.

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Table 2. Themes and quotes associated with answers provided to the open-ended questions: *Did the use of video calling lead to any other positive effects? And if so, which effects?; and Did the use of video calling lead to any other negative effects? And if so, which effects?*

Theme	Example quote
Being able to see each other	<p>"It's nice that you're able to see each other; it brings us closer"</p> <p>"I found video calling useful and was able to see my husband"</p> <p>"I'm able to see my mother, which makes me worry less. Now I can see whether she is doing well or not. This would not have been possible via a phone call."</p>
The relative does not understand video call technology	<p>"My mom didn't really understand how video calling worked. She didn't have support and was unable to end the application."</p> <p>"My wife doesn't understand video calling. She just sees a talking picture and therefore doesn't respond. Calling with a regular phone has a better effect."</p> <p>"My relative doesn't understand why I'm not visiting her, and I only have contact via FaceTime. Due to her disease she doesn't understand this and starts crying."</p>
Emotional burden on participants	<p>"I used to video call every day, but this caused too much emotional burden. After consulting with the nursing home, we decided that it would be better to call once every two days."</p> <p>"At times when my brother was uneasy and unresponsive during video calling, then that will continue to haunt you throughout the day."</p> <p>"During the call I always have to cry because you're not able to really see each other. I have a multi-handicapped brother, and you just don't know whether video calling does him good, which is very difficult for me."</p>
Missing physical contact	<p>"The call made the need for physical contact greater for me. I was confronted with his enormous deterioration. These things made me really sad."</p> <p>"My father has dementia and does not understand video calling. When he sees me he immediately wants to physically be with us."</p> <p>"You can see and hear the sadness of your relative, but you're unable to comfort them through physical contact."</p>
Deteriorating health status of relative	<p>"I was able to see how the health of my father deteriorated."</p> <p>"Now I see my relative fewer times per week, which makes changes in health status more apparent. My relative has a form of dementia and you can see how her health deteriorates."</p>
Lack of privacy	<p>"You're not able to have any privacy. "</p> <p>"I don't like the fact that my relative isn't really herself because someone sits with her during the video call."</p>



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Telehealth in Older Adult Mental Healthcare: A key weapon in the fight against the COVID 19 pandemic

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Key highlights:

- Telehealth services can facilitate access to mental healthcare services during the COVID-19 pandemic, as it limits unnecessary exposure of patients and health professionals to virus transmission.
- Challenges with video conferencing for healthcare provision with older people are broad, including lack of access to compatible devices, technology challenges and concerns about privacy.
- Older clients preferred telephone-delivered psychological services over videoconferencing and using a telephone landline rather than their mobile telephone.
- In rural and remote areas, unstable internet connections can make videoconferencing unfeasible.
- Both staff and clients had reservations about adoption of telehealth; however, over time these barriers have reduced
- New creative and innovative solutions, such as self-help resources for clients, have been developed during this pandemic with the intention of making care more convenient and more affordable.
- As more people are encouraged to use telehealth options, healthcare providers need to further adjust their services to improve telehealth- enabled patient- centered models of care and streamline procedures accordingly.

In January 2020, the World Health Organization (WHO) declared the outbreak of a new coronavirus disease, COVID-19, to be a Public Health Emergency of International Concern. In March 2020, WHO made the assessment that COVID-19 can be characterized as a pandemic [WHO, 2020]. As WHO and public health authorities around the world have been acting to contain the COVID-19 outbreak, government restrictions have been put in place, including social and physical distancing, to help prevent disease transmission.

Although these restrictions help to limit the spread of the coronavirus, the confinement of the population during lockdowns and the impact on healthcare services has been profound. Mental health services for older people have been facing significant disruptions, even as restrictions ease, given these older clients are

at higher risk of significant morbidity and mortality outcomes from COVID-19 [Howell et al. 2020]. In some contexts, this has included the complete cessation of all face-to-face and in-person assessments and treatments.

In this article, we explore how four Australian government-funded providers of mental health services for older people and people with age-related frailty have pivoted to continue providing vital care during 'social distancing' and quarantine requirements during the COVID-19 outbreak. The experience of clinicians and managers are described, as well as the barriers and facilitators of implementing online and telehealth interventions in Older People's Mental Health (OPMH) services and older adults during the COVID-19 pandemic were explored.

Setting

In New South Wales (NSW), a southern-eastern Australian State, with Sydney as its capital, publicly funded mental health services for older people (Older People's Mental Health (OPMH) Services), provide both inpatient and out-patient care to people aged 65 years and older, and Aboriginal and Torres Strait Islander people aged 50 years and older, with diagnosable mental health problems. The nature of the interventions offered at the specialist mental health care services are similar to those offered by general community services. They involve an initial mental health assessment, treatment and care planning by nurses, psychiatrists, physicians, psychologists, social workers and occupational therapists, or medication review. Inpatient care typically involves voluntary short-term management and treatment during an acute phase of mental illness. If necessary, the OPMH services will work with other services (e.g., community and residential care and support programs) to enable optimal care for the older adult. Given the remote location of many of these OPMH services in regional NSW, they are already well-equipped to use videoconferencing and telehealth approaches, and typically use these for the purposes of assessment, intervention, consultation, education and/or supervision. The experiences of one urban and three regional OPMH services in NSW are reported in the current article.

Impact on service provision

The OPMH services experienced significant disruption in usual mental health services delivery. In all OPMH services, in-person (i.e., face-to-face) services were being minimized or suspended. Regular mental health-care appointments and procedures scheduled to occur at the OPMH service or in client's homes were delayed, discontinued or reduced to prevent the spread of the virus. Managers and clinicians indicated that in-patient services were greatly impacted by the physical and social distancing restrictions with group therapy sessions, leave requests and family visits suspended. For the regional services, enforced travel restrictions impacted their service provision. Large community mental health services in regional areas provide outreach services to several other smaller, remote and rural towns.

Older adults living in these regional areas are highly dependent on the care they receive from the healthcare professionals of these larger OPMH services, as no local services are available due to geographic isolation. The discontinuation of regional visits by the larger teams created some unique challenges for health service delivery. This was exacerbated by the inability of professionals who normally ‘fly-in/fly-out’ to provide services given travel restrictions, leaving some towns without access to professional services.

Finally, the staff reported mounting pressure to shift to telehealth as a tool to give support to or facilitate the treatment of older adult people remotely. Although most of the OPMH services already provided some of their services via the telephone before COVID-19, the rapid move to use telehealth for all elements of care created a general feeling of unpreparedness and uncertainty for the clients and staff. In addition, the increased use of telehealth highlighted the need for a bolstered IT infrastructure to accommodate telehealth in the OPMH services.

Approaches used by OPMH Services to manage COVID 19

In response to the COVID-19 pandemic and its impact on service provision, the OPMH services indicated that they adjusted triage, evaluation, and care for patients. The OPMH services embraced telehealth, primarily using telephone consultations or videoconferencing in the provision of mental health care. Psychological services and internal staff meetings rapidly transitioned into telephone or videoconferencing consultations. The team managers and clinicians noticed an initial skepticism in patients about using



telehealth technology, with client preferences for telephone-delivered psychological services over videoconferencing, and preferences for landline telephone calls over mobile phone calls.

They reported that proposals to use videoconferencing for patient assessment and care created anxiety and stress among both clients and staff. Lack of knowledge and confidence in using the technology, privacy and confidentiality concerns, and concerns about the loss of social interaction, were common concerns reported by clients. Whilst some staff were able to adapt to use headsets to make telephone calls, some older people experienced physical difficulties holding a telephone for (longer) consultations.

Although the use of telehealth services is an established component in most OPMH services. The sudden increase and almost exclusive use of telehealth during the coronavirus pandemic identified some shortcomings in the infrastructure of these services. Limited availability of rooms and resources to conduct telehealth sessions while adhering to physical distancing, maintenance of equipment, internet connection instability in remote locations, and difficulties troubleshooting technical problems were frequently reported as challenges to the use of telehealth. In order to resolve some of these challenges, the three regional OPMH services, set up dedicated videoconferencing rooms at their services. These facilities enabled easy access to modern and efficient telehealth services for both mental health staff and clients, and the use of a reliable internet/telephone connection.

At the urban OPMH service, virtual waiting rooms were introduced to facilitate administrative processes and set up client's visits prior to the appointment between the client and their clinician. Virtual waiting room interventions allowing clients to interact, engage, and learn about mental health topics, are currently being explored as an opportunity to offer a variety of telehealth interventions within the current infrastructure. To increase access to videoconferencing technology for the patients, the regional OPMH services facilitated the purchase of iPads from clients' Home Care package funds. Since some services or support provided through a Home Care Package has discontinued due to the COVID-19 crisis, clients had more money available to allow the purchase of an iPad or other electronic devices for the purpose of telehealth.

In addition, in response to limitations in client contact and discontinuation of other supportive services for the older adult, the OPMH services developed a number of resources aimed to support improved care of older adult clients. Self-help resources, tips and information sheets – tailored to the needs of the individual patient, were sent to clients, encouraging them to practice therapeutic strategies between sessions. In addition, the urban OPMH service started sending out fortnightly newsletters, providing all clients involved in their service with general information about how to look after their own mental health, and up-to-date information on the implications of the COVID-19 crisis on receiving mental health care at their service. Furthermore, as geriatric neuropsychological testing is an essential service in older adult mental health care, services have developed resources to enable remote neuropsychological assessment, which are currently being finalized for implementation.

Directions for the future

The COVID-19 pandemic rapidly increased the focus on technology-enabled mental health provision in OPMH services across Sydney. While telehealth technology and its use are not new across the OPMH services, widespread adoption among healthcare staff and clients beyond simple telephone correspondence has been challenging. The over-dependence on IT systems as a result of the COVID-19 constraints, illustrated the insufficiency of telehealth system coordination and the technical challenges implementing telehealth as the primary modality in OPMH services. Although feelings of uncertainty and unpreparedness were some other unintended consequences of telehealth, the constraints also provided creativity amongst clients and healthcare staff. Staff and clients self-initiated education focused on developing foundational skills in the use of technology, enhancing independence and confidence. Furthermore, several innovative self-help resources were developed by the OPMH services to provide personalized support and will continue to be used as normal services resume. The OPMH services have strengthened their connections with other older adult support services by using the limited resources available in the most effective way, thereby adapting to a constantly changing environment. To enable continued access to mental health services and to overcome barriers to services associated with the COVID-19 restrictions, the OPMH services have embraced telehealth approaches during the coronavirus pandemic. Although initial steps have been taken to implement these models in clinical practice, developing greater capacity and support to provide technology-enabled older mental health care is still needed.

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Telehealth and Capacity Assessment

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The global COVID-19 crisis has necessitated adaptations to healthcare delivery, in order to minimize spread of the disease. While Telehealth has emerged as a key alternative solution for service delivery, one of the most challenging applications of this modality is capacity assessment.

Digital technology has been used across a range of public and private mental health, forensic and justice health services to undertake capacity assessments and clinical discussions. These assessments usually help guide important issues ranging from healthcare consents, guardianship and administration and testamentary capacity, to detention and deprivation of liberty for the purposes of care and treatment. The gravitas and impact of these assessments has mandated high standards to ensure that the technology is not a disadvantage to the person by inadvertent widening of inequalities nor increased future risk.¹

The COVID-19 pandemic and the exigencies to deal with such have posed challenges to the observation of some of the rights guaranteed under the European Convention on Human Rights (ECHR).² Notwithstanding this, in the UK the Court of Protection has taken pains to emphasise that “nothing has changed” as far as the obligation to safeguard the rights of the frail and vulnerable - often the subjects of these assessments.³

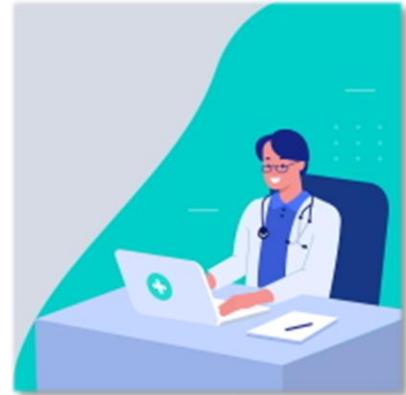
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COVID-19 and its exigencies have not removed the right of individuals to make autonomous decisions on personal matters or obviate the need for health or care professionals to ascertain whether individuals consent to their care and treatment, or to issues relating to their personal life. The first principle (s 1(2)) of the Mental Capacity Act⁴ in England and Wales is the assumption that we all have the mental capacity to make a required decision until proven otherwise and case law is also clear that an adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo and their consent must be obtained before treatment interfering with their bodily integrity is undertaken.⁵



Cognisant of the rights at stake, a recent judgment by the Court of Protection, acknowledged the necessity of remote assessments of capacity and the need for careful scrutiny of such:

Can capacity assessments be undertaken by video when it is established that P is happy to do so and can be “seen” alone?

Suggested solution: In principle, yes. The assessor will need to make clear exactly what the basis of the assessment is (i.e. video access, review of records, interviews with others, etc.) Whether such evidence is sufficient will then be determined on a case by case basis. It is noted that GPs are rapidly gaining expertise in conducting consultations by video and may readily adopt similar practices for assessments. Careful consideration will need to be given to P being adequately supported, for example by being accompanied by a “trusted person.” These considerations could and should be addressed when the video arrangements are settled. It should always be borne in mind that the arrangements made should be those which, having regard to the circumstances, are most likely to assist P in achieving capacity.’⁶

This latter statement, which also informed a guidance document, captures the key elements of a dignity and rights-sensitive approach to remote capacity assessments of vulnerable people, particularly those with cognitive impairment, namely:

- I. the importance of the person “being happy with” i.e. consenting⁷ to remote capacity assessment with all its inherent risks, as outlined below;
- II. ensuring that the person is seen alone. This is crucial to maintain rights of privacy and confidentiality, as well as safeguarding against abuse and undue influence, particularly for home-based capacity assessments if potential perpetrators of abuse are in proximity. The complexity of maintaining such privacy assessments for older people who may be hearing impaired or raise their voices during assessments has led to recommendations that practitioners screen for such concerns.⁸
- III. while maintaining privacy, the person may need the support of a trusted person to negotiate the technological challenges and optimize assessment⁸
- IV. promoting the fundamental human right to supported decision making, assisting the person, where possible, to “achieve capacity;”
- V. as with any medicolegal report, the basis of the opinion (e.g. video access, medical records, court documents, interviews with others) must be outlined in the report. While access to past records and legal documents such as Powers of Attorney financial records, past Wills and Affidavits, may be more difficult to procure for telehealth assessments, it is still important that opinions are comprehensively based and informed by adequate corroborative information.

Optimising communication, location, timing and support in order to put the person at ease and improving their ability to make a decision are all generic principles for best practice capacity assessment.⁹ It is essential that the capacity assessor has experience with conducting capacity assessments remotely and with available research and guidelines to ensure the reliability and validity of the assessment.⁸

Determining capacity is part of everyday work for health care professionals working in old age psychiatry.¹⁰ Notwithstanding the major challenges associated with remote capacity assessments, it is still business as usual as far as empowering people to make decisions for themselves where possible, including planning ahead for the future, while safeguarding them against abuse and undue influence. The stakes are high, and we cannot lower our standards. Capacity assessment by telehealth is not easy, but someone has to do it, properly.

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Using Telehealth in Long-Term Care Facility: an Experience from Thailand

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Key highlights:

- Telehealth services for residents in long-term care facility can prevent the spread of COVID-19.
- Telehealth can mitigate social isolation when face-to-face health delivery is restricted.
- Telehealth can maintain mental health education and services provided by multidisciplinary teams both among individuals and in groups.
- Telehealth offers much better time cost saving and should be promoted in mental health services to long-term care residents in remote areas.

Introduction

During the COVID-19 pandemic, every sector of healthcare service needs to adjust itself to the “new normal” to maintain adequate and proper services to patients. As physical distance policy is one of the effective methods to reduce COVID-19 transmission, long-term care (LTC) facilities for older people are also largely affected. We would like to share our experience in using telehealth care during the COVID-19 spike at our LTC Facility in Chiang Mai, Thailand.

LTC Facility

The Thammapakorn Social Welfare Development Center for Older Persons is a provincial LTC home, funded by the government and is 15 min away from Maharaj Nakorn Chiang Mai, Faculty of Medicine, Chiang Mai University. We, as one of a multidisciplinary team, comprising geriatric psychiatrists and psychiatry residents, occupational therapists, psychologists, pharmacist, gerontologist, and nurses, have been providing mental health (MH) services and education to staff and patients at this LTC home on a monthly basis since 2010. Since the government has legislated by emergency decree and declared public policies, as of March 2020, such as work-from-home, strict shelter-in-place and physical distancing, the hospital decided to hold the usual health services delivery to the facility. Our team, therefore, uses “telehealth” to provide virtual healthcare services to the residents and to continue with education and training to staff and caregivers.

Team Preparation

Staff, equipment and broadcasting facility preparation is the first step. The staff come from two teams, the hospital's MH team and the LTC Facility team. The hospital's team, including a geriatric psychiatrist and psychiatric residents, provide interviewing, examining, diagnoses, treatment planning, and prescribing. When a patient needs an immediate evaluation, physicians will provide a prompt investigation, intervention, or even transfer to the hospital. A clinical psychologist (and students) and an OT (and students) provide non-pharmacologic group treatment while a gerontologist offers individual counseling for the patients. The nurses from the Health Promotion and Disease Prevention play an important role in case managing and coordinating among team members. A pharmacist checks with rationale drug use, adverse drug reaction, and adherence.

On the LTC home side, the staff comprises social workers, nurses, an occupational therapist, and caregivers. Patients who can mobilize are queued while the immobilized ones are waiting at their beds. The patients were assessed for vital signs, brief cognitive tests (e.g., MoCA, MMSE), the Geriatric Depression Scale, and functional assessment beforehand.

Software/application and Device Preparation

The team uses Zoom® to deliver the telehealth services via computers, tablets, and smartphones due to its convenience in breaking into multiple rooms.

Activities at the LTC Home

The team members maintain the activities as usual, i.e., began with a 1-hour new **case conference**, which is an interprofessional team meeting. The nurse and the social worker at the LTC home prepare and present the case. Discussion about the resident's conditions is held by everyone to formulate a diagnosis and treatment plan.

After the case conference, each staff made a **virtual visit** with each patient in the breakout rooms. Psychiatry residents interview the patients and notify the geriatric psychiatrist staff at the main room to confirm with the diagnoses and, finally, plan for the management. The broadcasting space was set up in each individual's office using personal computers and a hospital computer, which is able to access the patients' data through the hospital server. While on the other side, staff and patients at the LTC facility connected to the telehealth program and broadcasted from a private space, i.e., meeting room, patients' beds. It was conducted a one-on-one, face-to-face basis. The same principle and process of approach as the usual face-to-face visit was employed despite using the virtual visit. The approach for each patient ended by lab investigating, prescribing medication, and scheduling the next appointment.

The holistic care concept and multidisciplinary care were also provided as usual, i.e., the **occupational group therapy** for cognitively intact residents and the **cognitive training/rehabilitation** group activities for residents with mild and major neurocognitive disorders. The total time spent on each visit is 3.5 hours on a monthly basis.

Benefits of Telehealth

Telehealth created an auspicious impact on MH care during the outbreak of COVID-19 due to the reasons stated below.

1. The team could maintain MH services to the LTC home. No incidence of depression was observed pertinent to social isolation.
2. Up until July 2020, no transmission of COVID-19 occurred among our team members, the case managers, or LTC residents and caregivers. This Telehealth method clearly demonstrates the efficacy of physical distancing.
3. Telehealth also benefits calling team meetings concerning a crucial situation. It provides team members a convenient and quick access to an urgent summons. For example, in June 2020, a completed suicide case was found at this LTC home. An urgent meeting was set up for a Morbid and Mortal Conference a few days later. Online meeting can overcome the fear of confrontation and reduces conflicts among team members.

Challenges

Although providing telehealth services is a very promising strategy during the “new normal” era, some challenges need to be dealt with.

1. Even though keeping distance cannot hold MH professionals back from providing services, physicians are limited in assessing by physical examination, which at times necessary to diagnose a condition or illness or to evaluate any adverse effects of psychiatric medications. We had one case with altered consciousness and debilitating weakness. The patient was brought to the hospital for a laboratory investigation and then received a diagnosis of hypokalemia and was properly treated at the hospital. This example demonstrates that acting upon the suspicious signs and symptoms should be warranted. Limitation of two-dimensional assessment of telehealth should be highly considered, while other alternative backup interventions should be promptly made available.
2. Visual sight and hearing problems are common among seniors. Some patients can poorly observe therapists through a tiny monitor. Moreover, some cannot hear properly from the devices' speakers. The barrier also has limited capacity to be adjusted for higher quality communication.
3. Difficulty is encountered using the technology. Some team members were unfamiliar with such technology and struggled using these platforms, e.g., difficulty in sharing the presentation, splitting groups or moving between rooms, or even connecting or reconnecting the internet. Nonetheless, the difficulties can be overcome by practicing and supervising. Maintaining a stable internet connection is the crux of the matter. An alternative backup network may probably be the best policy.
4. Confidentiality. Confidentiality is one of the core values of medical ethics and may be a highly sensitive issue for patients with mental illnesses. Our team is tremendously focused and concerned about this issue. Every healthcare provider and related personnel need to pre-register before joining the meeting and would be provided with the password to access the meeting. The team members endeavor their best to ensure reliable confidentiality using the most trusted platforms recommended by the university and encouraging members to practice medical ethics.

In conclusion, telehealth services at LTC home provide knowledge and experience. Benefits, limitations, and difficulties have been investigated, yielding improved telehealth services. This type of service may help establish guidelines and create a model for future practice in geriatric telemental health settings in Thailand.

Click here to watch a short video: <https://vimeo.com/446609461>



From left: Prof. Nahathai, Prof. Tinakon, Dr. Issaren & Dr. Narawit

Prof. Nahathai and Prof. Tinakon are geriatric psychiatrists.

Dr. Issaren and Dr. Narawit are psychiatry residents.

Ms. Yupapan is an occupational therapist, and Ms. Pairada is a clinical psychologist.

Memory unit's care for people with dementia and their caregivers in the context of the COVID pandemic: facilitators and barriers to remote care. The Chilean experience

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The effects of COVID pandemic are particularly challenging for people with dementia (PwD) and their caregivers (Wang et al., 2020). The pandemic has caused important discontinuation of care of people with chronic illness (Allegri, R. & Sevlever, G., 2020). Quarantines and physical distancing have been associated with the worsening of both PwD and their caregivers (Wang et al., 2020). Besides, PwD are not free from being infected by COVID and are at high risk for serious complications of a COVID infection due to the high prevalence of comorbidity in PwD.

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Due to all of the above, it is particularly important to ensure the continuity of care in PwD and their caregiver while promoting a strict follow-up of all the safety measures, including physical distancing. The “Clínica de Memoria y Neuropsiquiatría” (CMYN) of the Hospital del Salvador, one of the three public memory units in Chile, was founded in 2017 in the context of the implementation of the Chilean’s National Plan of Dementia. CMYN is composed of a multidisciplinary staff specialized in the diagnosis and the post-diagnostic support for people with dementia and their families, mostly for outpatients (Custodio et al., 2017).

The clinical staff from CMYN has followed the directions of the Ministry of Health on minimizing face-to-face care, especially considering that the population in treatment belongs to the higher risk group in case of COVID-19 infection. Teleworking has been promoted to ensure continuity of care. At the same time, to reduce social interactions for the sake of healthcare workers, staff alternated on a shift system and assistance to the hospital was reduced to one medical professional and two non-medical professionals by day to attend spontaneous consultations to CMYN.

Through teleworking, we were able to maintain multidisciplinary work both for care, with teleconsultation, and for clinical discussion of patients.

Also, we have continued to offer several interventions via telemedicine, in either video or phone call:

- I. Medical consultation of previously scheduled patients.
- II. Spontaneous consultation of patients in treatment in case of clinical worsening, or need of renovation of medical prescription, or any other specific need
- III. Diagnostic information to patients and their relatives
- IV. Post-diagnostic support after diagnosis by a clinical psychologist and social worker for the relatives.
- V. Case management, conducted by the nurse staffing, checking patients who may require controls and promoting telephone guidance for those requiring it. Besides, contra-referrals and case-reports to primary care.
- VI. Teleneuropsychology sessions. In some cases, the patient was evaluated with abbreviated evaluations via video call.
- VII. Exceptional in-patients’ consultation in cases of rapid onset dementia or medical emergencies.

The main facilitators to the implementation of remote attention were:

- Availability of web-based electronic health registry (EHR) previously developed by CMYN, with the support of the engineering department of the University of Chile. Our EHR has two main purposes: a) to the registry of relevant health information related to the brain disorder for which the patient is being evaluated and treated in CMYN, and b) to enable management and communication of multidisciplinary teams for person-centred care. It is important to highlight that Hospital del Salvador has not a shared EHR for all the services. The availability of an EHR has been very relevant to assure continuity of care during the pandemic. It enables the teleworking of the health professionals of the memory by providing remote access to clinical information and facilitates teams’ communication.

- The flexibility of the administration that authorizes substituting face-to-face consultation by telephone consultations. Finally, the health service implements a system to enable the delivery of medications, prescribed in teleconsultation at the hospital, in primary care centers.

Nevertheless, there are significant barriers to dementia care in the pandemic context that can be summarized in four main categories:

- I. Barriers to clinical care: it is very difficult to realize new-patient consultation: Chilean regulation limits telemedicine to follow-up consultations in the case of neurology and psychiatry. There are not well-validated teleneuropsychology instruments to perform remote neuropsychological evaluations. Moreover, due to the burden of care associated with COVID pandemic, non-COVID outpatients have very restricted access to laboratory exams and neuroimaging. All of the above has provoked and suspension of the evaluation of patients in the diagnosis process previous to the pandemic and an increase in the waiting list.
- II. Connectivity barriers: In the majority of cases, contact is limited to telephone calls due to low access to good high-speed internet or lack of access or low familiarity with the use of computer and webcam to perform other sorts of remote medicine. Sadly, most users did not have the connectivity tool for an appropriate evaluation, such as smartphones, webcam, or a steady internet connection. Additionally, we haven't registered available resources to remote contact before the pandemic. Besides, the hospital did not provide connectivity tools to the professionals, and each professional have to use its smartphone and assume the cost of the calls.
- III. Shortage of human resources: some of the health professionals of the memory unit were assigned to other services of the hospital or provide psychological support to COVID patients and first-line health staff. For example, the speech therapist was fully assigned to in-patients.
- IV. Barriers to research: Due to the pandemic situation, most of the research projects were suspended. However, we will able to start two research protocols on the impact of physical distancing on PwD and their caregivers: a multicentric protocol administered by phone and on-ongoing online surveys for caregivers. We are also participating in another multicentric study of the impact of COVID-19 on older Latinos' well-being and cognition



Conclusions:

Although we manage to keep remote consultations, the pandemic has had an important impact on the continuity of care in dementia. The main problem is the inability to attend new patients, with the increase in the waiting list. There is a need to implement in-patients' consultations with physical distancing measures and better telemedicine, including well-validated teleneuropsychology protocols. The impact of the pandemic on the memory unit also needs to be evaluated.

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LEAVING THEM BEHIND: OLDER ADULTS AND VIRTUAL MENTAL HEALTH CARE IN THE ERA OF COVID 19: EXPERIENCES FROM A NIGERIAN HOSPITAL

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INTRODUCTION

The coronavirus, SARS-CoV-2-causing Coronavirus Disease-19 (COVID-19), emerged as a public health threat in December 2019 and was declared a pandemic by the World Health Organization (WHO) on the 11th of March 2020.¹ COVID-19 is a highly transmissible disease affecting all ages with a disproportionate impact on older adults, especially those with comorbidities.² To mitigate the spread of the disease, various preventive measures were taken by governments and public health authorities including Nigeria, such as hand washing with soap and water, using face masks, and physical distancing. Community and religious leaders were also recruited to help in public enlightenment exercises. Varying degrees of lockdown and restrictions were imposed across the country resulting in the utilization of telecommunication tools to provide mental health services by some facilities.

The Jos University Teaching Hospital is a 530-bed capacity hospital established in 1981 which has two (2) outposts in the rural communities of Gindiri and Zamko in addition to the main hospital located in the state capital of Jos (urban area). It has over 130 specialists in different fields including Psychiatry, Neurology, Community medicine, Family medicine, Internal medicine, Surgery, Paediatrics, Obstetrics and Gynaecology, Haematology, Microbiology and Radiology amongst others.

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MENTAL HEALTH SERVICE DELIVERY PRE-COVID-19 ERA

It is estimated that about 6% of Nigerians are 60 years and above, and a considerable proportion reside in the rural communities.^{3,4} These communities are fraught with challenges such as poor facilities, limited access to mental health care (as the bulk of mental health practitioners practice in tertiary health care facilities in the big cities of Nigeria) and poverty.^{5,6} Prior to COVID-19, mental health service delivery to older adults in Nigeria was subpar, especially in the Northern parts of Nigeria.⁷ There already exists a huge gap of unmet mental health services for older adults, which have been fueled by factors such as stigma, poor awareness that older adults suffer from mental illness, deficient primary health care services, inadequate community healthcare workers and few psychogeriatricians.^{6,8} Furthermore, the existing cultural practices and belief systems encourage the perception of mental illnesses in the older adults as a punishment by a deity for a past misdemeanour.⁹ However, with increasing awareness and enlightenment, the general public are beginning to realize that older adults can suffer from mental illnesses and recognize the benefits of orthodox management of mental illnesses.

Consultations in northern Nigeria had always been face-to-face, requiring older adults with mental health problems to access care at secondary and tertiary mental health facilities mostly located in big cities. Most of our patients travel at least 63 miles to access services at our facility, a teaching hospital located on the outskirts of the state capital, and they are usually conveyed via commercial vehicles accompanied by relatives or caregivers. We run weekly Psychogeriatric clinics in the Teaching Hospital; however, this does not deny access to daily consultations at the emergency units. An average of 35 patients are seen at the weekly Psychogeriatric clinic with an average of 3-5 new cases per week. Depending on severity of symptoms, some may require admission, but most are managed on an outpatient basis. Commonly seen cases among older adults are depression, dementia, late-onset psychosis and substance-related problems. Interestingly, most are referred by friends or family members with a few from other specialties in the hospital. Nursing homes are still a relatively novel concept in Nigeria, and currently no documented findings are available from the few in existence.

MENTAL HEALTH SERVICE AMID THE COVID-19: SETBACKS AND SUCCESSES

The fragile nature and obvious weaknesses of the health care system in Nigeria such as poor funding, inadequate and ill-equipped health facilities and inequitable distribution of resources was thoroughly exposed by the outbreak of COVID-19.¹⁰ With the total restriction of movement imposed during the lockdown, public transportation was banned making it difficult for patients to access care. The hospital's outpatient services were suspended in the initial weeks of the lockdown. Private pharmaceutical stores were either closed or had run out of most medications leaving hundreds of our patients unattended for over two months.

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The unavailability of care was frustrating for patients, and they did not know when they would see their doctors again which had detrimental effects. We received telephone calls and messages from caregivers with complaints such as agitation, disorientation, elopement, aggressiveness and lack of sleep. The uncertainty and fear of infection with COVID-19 through hospital visits persisted long after the lockdown ceased. Most of the patients who had comorbid medical conditions or exacerbation of pre-existing mental illness were discouraged by relatives/caregivers to come for care in the hospital.

These challenges made it necessary to utilize innovative services using available and accessible telecommunication tools such as telephone calls and SMS messages; this would reduce the risk of COVID-19 transmission to relatives / care-givers and community healthcare workers, while meeting the mental health care needs of older adults. Some older adults and their relatives and caregivers could readily access virtual consultation and psychotherapy sessions from their health care providers. However, only an infinitesimal proportion of our patients benefited from this level of care.

With the easing of restrictions almost all older adults who could readily communicate preferred face-to-face consultations despite access to varying levels of consultation via digital tools; they report that routine trips to the hospital gives them a “breath of fresh air” and a sense of relevance and belonging. The isolation



and loneliness from not seeing their younger relatives frequently during the periods of total lockdown were particularly difficult for them. It also exposed feelings of neglect associated with not being informed of happenings around them by their relatives in a society that operates a strong extended family system.¹¹

Our experiences show that the use of virtual platforms and Tele-psychiatry will improve health care delivery.¹² However, implementing Tele-psychiatry in Nigeria, a Lower Middle-Income Country comes with several limitations. These includes the apparent inability of health facilities to liaise with telecommunication organizations, funding, sustainability, poor literacy using electronic devices, and a high level of poverty among older adults. These serve as obstacles in preventing older adults' access to simpler and affordable forms of telecommunication such as smartphones, which in turn could be used for consultations.

CONCLUSION

Delivery of healthcare service using virtual means may be the solution to meeting the mental health gap. There is a need to balance virtual consultations with face-to-face appointments in older patients to avoid social isolation which can worsen mental health conditions. Hence, there is a need for countries like Nigeria to address these challenges to enable a robust Tele-psychiatric practice, thereby ensuring that older adults in Nigeria are not left behind.

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