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The Challenges of Hospitalized Older Adults with Psychiatric Disorders

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There is a shortage of professionals who provide geriatric mental health services [1, 2]. It is estimated that by 2030 there will only be 1650 geriatric psychiatrist in the United States or one geriatric psychiatrist per 6000 patients with mental health and substance-use disorders. In addition, approximately 14% to 20% of the overall population over age 65 has at least one mental health or substance use condition that will have substantial negative effects on patient's health and well- being. It has been shown that mentally ill older adults are likely to have greater disability, worse health outcomes and higher rates of hospitalization and emergency department visits than older patients with a physical condition only [1, 3, 4]. The cost per person with mental illness and a medical illness is estimated at 47% to 200% higher compared to patients with just a medical illness [1, 3].

This is a nationwide geriatric mental health crisis and what are clinicians in acute care settings to do? There are not enough geropsychiatry consultation services available in acute care settings and psychiatric consultation services, which may not be aware of expected physiologic changes of aging, vary significantly from institution to institution. It is incumbent upon critical care health professions caring for older adults with psychiatric illness to be proactive and ensure that screening, monitoring and treatment of the psychiatric disorder are provided.

In a paper I wrote with colleagues titled "Psychiatric disorders impacting critical illness" [5], we discussed complicated issues of older patients with psychiatric disorders and medical illness in acute care. The intent of the article was to prepare acute care nurses to recognize and meet the mental health needs of older adults with critical illness and prevent untoward sequelae of medical events. The most prevalent conditions seen in hospitalized older adults include: anxiety, mood disorders (e.g. depression bipolar), substance dependence, and dementia. Many of the behavioral and psychological symptoms in older adults with the above conditions can be exacerbated by a medical illness. If those behavioral and psychological symptoms aren't recognized, inappropriately aggressive physical care may ensue. In addition, clinicians need to recognize exacerbation of psychiatric symptoms to prevent escalations in behaviors that will make it difficult for patients to adhere to medical procedures and treatments. Finally, the stigma of taking care of a patient with a psychiatric condition who has a different physical appearance or unusual behavior may get in the way of appropriate medical care. Clinicians need to put aside false stereotypes and establish a trusting relationship with the older adult patient with a psychiatric disorder.

The recommended goals of care for hospitalized older adults with mental illness in the article include:

1. Routinely assess for undiagnosed psychiatric illness in all older adults and exacerbations of psychiatric symptoms for those with an established diagnosis
2. Recognize the special needs and unique presentation of psychiatric disorders
3. Create an environment of safety
4. Maintain functional abilities and strength
5. Prevent excess disability
6. Improve quality of life
7. Provide continuity of care and use outpatient mental health services.

To improve acute care hospitalization interventions and outcomes of critically ill older adult patients with comorbid psychiatric disorders it is important to obtain the patients current psychiatric status. According to the article, information should include: psychiatric diagnosis and current psychiatric provider contact information, past psychiatric hospitalizations, suicidal/homicidal history, prior psychotropic drug trials, occupational, functional, social and mental status history. Recent cohabiters or family members of the patient who know about recent life events that can describe the patient's baseline and symptoms of psychiatric decompensations. Next of kin, health care proxy, legal guardianship as well as status of legal mental competency will also help determine treatment care options. In general, within the field of critical care, there is increasing agreement on the principles of shared decision making and the importance of caring for patients' families as well [6].

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This author recommends training in assessment and evidence-based treatment of common geriatric mental health and substance-use disorders be provided to all acute care nurses in order to recognize psychiatric changes from baseline and provide brief interventions. In general, health care professionals want to control behaviors and expect older adult patients with mental illness to "act normal". Understanding neuropsychiatric behaviors will help acute care nurses develop behavioral strategies and be more tolerant of behaviors that do not put the patient or health care providers at safety risk.

In a recent editorial titled "Common sense: addressed to geriatric psychiatrists on the subject of behavioral and psychological symptoms of dementia" [7], Dr. Helen Kales discussed the importance of using nonpharmacoloigc strategies and the development of more specific neurobiological treatments. Dr. Kales challenged the geriatric psychiatry community to move past the decades old use of psychotropic medications and strive to improve both the science and real-world treatment of behavioral and psychological symptoms of dementia (BPSD). Her call to action regarding behavioral and psychiatric symptoms of geriatric hospital patients with dementia is applicable to the behavioral symptoms seen in mental illness as well. Dr. Kales discussed Action Item 1: Reject the search for one magic bullet for BPSD. Disruptive behaviors are complicated and multifactorial. Neurobiologically related disease factor, acute illness and psychiatric illness factors as well as caregiver and environmental factors contribute to behavior. Action Item 2: Condemn approaches to BPSD that involve reflexive use of psychotropic medications. The excessive dependence on treating difficult behaviors with psychotropic medications may more be related to staff anxiety rather than looking for modifiable causes that would have more impact and less medication side effects. Finally, relevant to this commentary is Action Item 3: Embrace behavioral and environmental ("Nonpharmacologic") strategies in the treatment of BPSD and become expert in their use. While Dr. Kales recognizes the importance of biopsychosocial models in the care of older patients with mental illness she reports that geriatric psychiatry has not taken the lead in the use of modalities other than prescribing medications.

In summary, acute care nurses will play a larger role in the care of critically ill geriatric patients with comorbid mental illness. More education is needed related to the signs and symptoms of common geriatric mental disorders and non-pharmacological treatments options. Collaboration between psychiatry and acute care health providers and developing new models of care will facilitate and effectively manage psychiatric and medical illness in the hospitalized older adult patient.

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