

# **Mental Health Issues Facing Older Women in Nursing Homes**

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Minnesota currently has about 30,000 nursing home residents, a number that has fallen over the past 30 years as other senior housing options have become more prevalent as well as home health care services. 84% of nursing home residents are over 65 and 70% are women. 65-91% of nursing home residents meet the criteria for some form of mental illness; this estimate has been consistent for many years and is consistent across several western nations (Canada, the UK and the US). It is obvious that competent mental health care for this population is essential.

Admission to the nursing home is often abrupt, occasioned by acute illness or injury resulting in hospitalization and then transfer- usually to a transitional care unit and then possibly to long-term care- whereas moving to assisted living is usually more planful. Women coming into the nursing home setting have often lost loved ones, are usually giving up a home and almost all of their belongings, typically have limited financial resources and in almost all cases were not planning on this as part of their life trajectory (even though the lifetime risk of nursing home placement is 40%). Often they have lost a pet in the process and this can be a powerful source of distress, especially if the pet had to be euthanized. Once in the nursing home, there is frequently a loss of privacy (roommates, caregivers), diminished sense of agency, less contact or visitation from family and friends, loss of dietary choice, etc. Despite this most residents make a more or less successful transition and some thrive. However, it cannot be denied that nursing home placement often has a significant negative impact on mental health. In my experience, adjustment disorders are very prevalent during the first 6-12 months of nursing home placement; these may be superimposed on preexisting conditions. There are positive factors that can be marshaled to reduce these problems: establishing positive connections with caregivers and peers, maintaining contact with family and friends, engagement in meaningful activities, promoting physical activity, maintaining good sleep hygiene and nutrition, etc.

When discussing the mental health of older women, the first typical concern is cognitive impairment. At age 65 about 4% of women are thought to have cognitive impairment but by age 85 this rises to 20%. However, there is also research indicating that the incidence of dementia in older adults has fallen about 13% per decade over nearly 30 years in Europe and the US. Incidence among men has fallen by 24% while decreasing only 8% for women. The reasons for this decrease are not clear; there is some thought that treatments to reduce blood pressure, cholesterol and inflammation may be contributors. A factor in the difference in decreased incidence between men and women may in part be accounted for by women's longer average lifespans- incidence diverges around age 80 for Alzheimer's dementia and around age 85 for the other dementias.

Unsurprisingly, about 65% of nursing home residents suffer from dementia and many of those suffer from comorbid psychiatric symptoms. Psychotic symptoms occur in 25%-40% of people with dementia (some studies estimate as high as 70%). Depressive symptoms occur in up to 50% of people with dementia and anxiety up to 70%. Comorbid psychiatric symptoms are associated with increased risk of behavioral problems in people with dementia; collectively these are known as behavioral and psychological symptoms of dementia (BPSD). These symptoms are a prominent driver of psychotropic medication prescriptions in older women.

In addition, all of the mental health issues that can occur earlier in life can be present in older women whether cognitive impairment is present or not. Among older adults the numbers in the research- much of which is close to 30 years old- vary considerably; at least 15% of people over 60 are thought have some form of a mental health disorder. Older women report mental illnesses at lower rates than do younger women up until about age 75, when prevalence begins to increase.

Suicide is a particular consideration for patients over 60, with completed suicides being more common in men than women. Suicidal ideation is relatively common, estimated at up to 33% reporting such thoughts in the past month; self-harming behavior is relatively lower. The research is surprisingly scanty; active suicide in the nursing home setting is slightly less common than among elders in the community (14 vs. 16 per 100,000); about 40% of nursing home suicides are women which is much higher than the lifetime statistic (20%). Passive suicide is more difficult to identify and track, such as stopping eating.

Elder abuse is an under-recognized epidemic which includes physical, verbal, sexual, financial abuse, abandonment and neglect. About 1 in 6 older adults are thought to have experienced abuse which may lead not only to physical health impairments but also depression and anxiety. Elder abuse is a crime and should be treated as such. In a 2020 WHO study, 64% of nursing home staff admitted abuse or neglect of a resident; 44% of nursing home residents state they have been abused in some way (including abuse by other residents) and 95% report neglect. The prevalence of abuse and neglect in assisted living facilities is not as well known but may be similar. The most common form of abuse reported is verbal/emotional. Residents frequently do not report abuse or neglect due to cognitive impairment, embarrassment, fear of being disbelieved or of retaliation.

Psychotropic medication use is prominent in elder care settings. In Minnesota 15.2% of long-term care nursing home residents were prescribed a neuroleptic according to CMS/Medicaid data; the median utilization rate in the US is 15.1%. Most neuroleptic use in the long-term care setting is off-label and there has been a trend of diagnosing residents with schizophrenia to justify the use of the medication- an increase in new diagnoses by some 70% since 2012. The most common uses of neuroleptic medications in nursing homes is to reduce non-cooperation with care, agitation and aggression in individuals with cognitive impairment. This utilization creates a regulatory risk for the facility, since punitive measures can be applied for inappropriate use. Neuroleptics, sedative-hypnotics and anticholinergics are the psychotropic medications of greatest regulatory concern in this population. Neuroleptic use doubles the risk of all-cause death in this population. The majority of psychiatric medications are prescribed by non-psychiatry providers.

The regulatory environment in which nursing homes operate has strict rules around the use of psychotropic medications. If a medication is used in a resident without an appropriate diagnosis, such as schizophrenia when prescribing a neuroleptic, the use of the medication is considered a restraint. The use of psychotropics is tempting because the staffing ratios required of nursing homes are much lower than in hospital settings but nursing homes are not allowed to restrain residents. Physical restraints were banned in 1990, which unintentionally resulted in a dramatic increase in the use of psychotropic medications to reduce adverse or unwanted behaviors. Nursing homes are required to attempt non-pharmacological interventions first such as group and individual activity programming, psychosocial services, behavioral management programs (e.g., reward programs), exercise programs, pain management, etc. Most of my job is guiding those interventions.

When residents are on psychotropics, in most cases the facility is regulatorily required to do trial gradual dose reductions or to get documentation as to why this would be contraindicated. In the case of neuroleptics, there is an exception for schizophrenia. Closer attention tends to be paid to neuroleptics, benzodiazepines and sedative-hypnotics than to antidepressants and mood stabilizers. Many nursing homes have a Minimum Effective Dose committee which typically includes a pharmacy consultant, mental health professional, nursing and social services staff which review the medications, diagnosis, current indications for treatment, interval since last dosage change and whether adequate supporting documentation is available. I had the privilege of helping to develop this model in 1992. In most cases, if there is a concern the facility or the pharmacist will send a note to the prescriber asking about a trial dose reduction or for documentation as to why this would be contraindicated.

In conclusion, it seems that much of this information sounds bleak. It should be noted, however, that nursing home can provide excellent care and a positive quality of life for the women residing in them. This presentation is written during the COVID-19 pandemic which has had major effects on nursing home life and has resulted in severe staffing issues impacting quality of care. Mental health providers can play a critically important role in addressing the needs of older (and younger) women in these settings.