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These could be submitted as regular articles, reviews or brief reports. Brief reports may involve preliminary results of ongoing research, clinical hypotheses and front-line perspectives on rehabilitative care and treatment delivery.

Editor: J. D. Mendonça PhD, CPsych

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Manuscripts submitted for publication must follow the rules of APA Style® detailed in the *Publication Manual of the American Psychological Association.* For more details visit the APA website.

Regular articles (not to exceed 4000 words) should contain the following sections: 1) Title page 2) Structured Abstract with Clinical Implications and Limitations, and Key Words 3) Body Text with Tables / Figures, References (as per APA style) and 4) Funding Support / Acknowledgements.

Brief reports (not to exceed 1500 words) may be submitted in the usual APA style or in two additional variations given below (while observing the APA citing and referencing style).
1) *Front Line Perspectives*
The submission would consist of a description of actual or prototypical cases (n < 5, from hospital or community settings, de-identified, with patient consent placed in the clinical file).
Sections: Abstract, Introduction, Case Review, Commentary, Conclusions.
2) *Clinical Hypotheses*
A hypothesis should include an organized structure of known facts and their real world impacts that are observable.
Sections: Abstract, Introduction, Hypothesis/Theory, Evaluation Pilot Data (if applicable), Clinical and Research Implications, Conclusions.

The editor may be approached for any unique manuscript variations required by the subject matter.

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COVID-19 Challenges

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Optimizing Mental Health Care for Seniors While Adjusting to COVID-19 Pandemic Public Health Regulations

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Coronavirus disease 2019 (COVID-19) disproportionately affects the geriatric population. During the pandemic caused by the disease, strict public health measures have been put in place by the government to limit the transmission of the virus. However, there are negative psychological effects due to social isolation stemming from these measures leading to relapses in Depression and Anxiety. Also the disruption of services and limited face-to-face interactions, have placed a strain on older adults who require these for independence and cognitive and emotional support. We present a review of various implications of COVID-19 restrictions, their effect on the geriatric population and how the Geriatric Program at Parkwood Institute Mental Health adapted to overcome these challenges. Our aim is to inform caregivers and health care providers of the need for flexibility and innovation when delivering care to older adults during the pandemic.

Keywords: COVID-19, mental health, seniors, older adults

On March 11, 2020, a pandemic was announced by the World Health Organization (WHO, March 11, 2020) after a novel coronavirus SARS-CoV-2, originating from the Wuhan region of China, causing the coronavirus disease 2019 (COVID-19) spread worldwide (Vinkers, van Amelsvoort, Wang et al, 2020). It also appeared that the virus negatively affected the geriatric population more so than the rest of the population, with its case fatality rate increasing from 2.3% to 8.0% in patients 70-79 years old and 14.8% in individuals 80 years and older(Wu & McGoogan, 2020).

In order to limit the spread, Governments around the world put in place strict public health and lockdown measures (Vinkers, van Amelsvoort, Wang et al, 2020) such as hand washing, wearing masks, restricting large gatherings, restricting travel and physical distancing. As a result, many individuals were unfortunately at risk of worsening depressive and anxiety symptoms such as people of low socioeconomic status, people with psychiatric disorders and the elderly (Vinkers, van Amelsvoort, Wang et al, 2020). Special attention should be given to the older population, as they are the most vulnerable to isolation, thereby exacerbating feelings of loneliness (Vinkers, van Amelsvoort, Wang et al, 2020) and health problems, such as depression and cognitive impairment (Cacioppo & Cacioppo, 2014).

Canada has been implementing its response to the COVID-19 pandemic using its experience with the severe acute respiratory syndrome (SARS) epidemic of 2003 that resulted in over 400 cases and 44 deaths in Canada (Webster, 2020). Decreasing preventable hospitalizations and treating people at home when possible proved to be most beneficial. It was established that health care providers could help patients while simultaneously reducing risk of exposure (Webster, 2020).

The Geriatric Psychiatry Program at Parkwood Institute, a tertiary care hospital in London, Ontario, provides care to older adults with diverse mental health illnesses. It has various services including inpatient care (42 bed capacity), consultation service, ambulatory clinics, and outreach teams that service about 7 counties in Southwestern Ontario. These services receive referrals from the acute site at London Health Sciences Centre and other partners in the region and adapt to the changing demands to

better assist the geriatric community. This paper will look into the implications of various public health measures for the infirm elderly and how the geriatric psychiatric program at Parkwood institute has adapted to provide effective and flexible care according to COVID-informed practice guidelines.

Proto-typical Case, Service Disruptions

An elderly woman was referred to the Geriatric Program after seeing multiple physicians for sleep difficulties, fatigue, confusion and decline in cognition. A Montreal-Cognitive Assessment (MoCA) previously completed in March of 2019 was 17/30 and due to this her licence was suspended. Initially, losing her license resulted in social isolation, but she was able to continue functioning with the support of her neighbours and friends who drove her to get groceries and attend social gatherings. However, once the pandemic started with various restrictions, her friends were no longer available for support. She started to experience low mood, anhedonia and worsening anxiety when going to the grocery store. She voiced that the only relationship she was able to maintain was one with her pet dog, who gave her assurance and reduced her anxiety in public places. The clinical team provided her with problem-solving therapy (Alexopoulos, Raue & Arean, 2003) to facilitate solutions for her social isolation and optimized her medications to help with anxiety and depression. In addition, support was provided for her application to designate her pet as a therapeutic pet, which allowed her to continue caring for daily needs independently.

As seen in the above case, an individual's ability to live in the community may be threatened in various ways from the disruption of services due to the pandemic. For example, unreliable meal delivery services, lack of at-home support, and relying on public transportation pose risks to individuals. Those who live in group or assisted living or long-term care homes are at increased risk of infections due to large groups, over-crowding and higher dependence on caregivers, who may also work at multiple sites (Brown, Kumar, Rajji, et al., 2020).

An additional problem in long-term care settings is the lack of available personal protective equipment (PPE) on site for staff members (Mills, Kaye & Mody, 2020). These facilities also adjust to new infection prevention strategies much later than hospital settings (Mills, Kaye & Mody, 2020). Health care workers are at high risk of infection from COVID-19 and are then at risk of infecting elderly patients with severe dementia who are often admitted to hospital for behavioural issues. Elderly people with severe cognitive and behavioural symptoms of dementia are less able to monitor their own care or advocate for themselves, making it harder to know when help is required (Brown, Kumar, Rajji, et al., 2020).

With the increase in community spread of COVID-19, non-essential visits to long term care and retirement homes were suspended causing more isolation among residents and reduced physical activity (Mills, Kaye & Mody, 2020). With limited social interactionin the long-term care homes, perceived loneliness can lead to difficulty with sleep and accelerated brain aging, which puts people at increased risk of dementia (Cacioppo, Hawkley, Norman & Bernston, 2011). Lack of physical closeness to others, confinement and sleep disturbance that disrupts social rhythms can also increase risk of delirium in the elderly (Richards, Beck, O'Sullivan & Shue, 2005). Social isolation can also lead to self-neglecting (Locher, Ritchie, Roth et al., 2005) and self-harming behaviours such as substance use and suicide (Hanson, 1994; Eng, Rimm, Fitzmaurice & Kawachi, 2002; Berkman, Glass, Brissette & Seeman, 2000).

During the first phase of COVID-19, all ambulatory visits at Parkwood Institute Mental Health were put on hold due to factors that were consistent with local and provincial practices to reduce the risk of transmission. Reassignment and redeployment of staff also occurred to support other high needs services. This resulted in several service disruptions. Assessments for patients who were referred for diagnostic clarification and care were delayed. Patients who were already registered with the clinic and needed regular follow up experienced a decrease in access to geriatric day programs, social services and community agencies. Unfortunately, with limited paid caregiver support and less visits from family members, many elderly individuals started to deteriorate at the start of the pandemic. The

geriatric psychiatry program had to find ways to support new referrals and existing patients by using other methods to provide care, which are discussed below.

Commentary: Modifications in Hospital and Community Care

With safety measures in place, outreach teams were enabled to continue home-based interventions as this has proved to have better outcomes than office-based interventions, in terms of quality of life and functional and emotional gains (Ciechanowski, Wagner, Schmaling et al., 2004). In-home nursing health evaluations and phlebotomy were also made available in order to limit individuals needing to take a trip to the clinic or lab and thereby risking exposure (Steinman, Perry, Perissinotto, 2020). It is important to attend to unmet social or functional needs early to prevent hospitalizations. This would involve enlisting help from geriatricians and other clinicians who have greater expertise in the care of older adults to assess goals and appropriateness of interventions (Berian, Rosenthal, Baker, et al., 2018). Caregivers can then ensure that people are wearing their glasses or hearing aids and practicing using technology ahead of time to better equip them for virtual care visits (Steinman, Perry, Perissinotto, 2020).

The health and safety of healthcare workers should be a matter of continuous concern and training with standardized education maintained in key practices like hand hygiene and use of personal protective equiptment (PPE) (Grabowski and Maddox, 2020). Policies regarding sick leave and staff retention should be prioritized. Institutional medical directors, corporate leadership and local health department authorities are encouraged to be transparent and open lines of communication to allow for quick organization of infection control response plans (Grabowski and Maddox, 2020).

To cushion the impact of a significant decline in home visits compared to previous years, the Geriatric Program teams reached out in alternate ways. From March 11 to July 31, 2020, they provided a number of virtual visits to support patients, families and community workers (See Figure 1).

Home visits were completed for cases pertaining to essential assessment or treatment, such as long-acting injections or monitoring treatment adherence. With the decline in home visits, there was a significant increase in telephone contacts. Video assessments were newly implemented and were facilitated with assistance from family members and nursing staff in long term care homes. This allowed for direct visualization of patients for diagnostic clarification, medication management and monitoring of side effects.

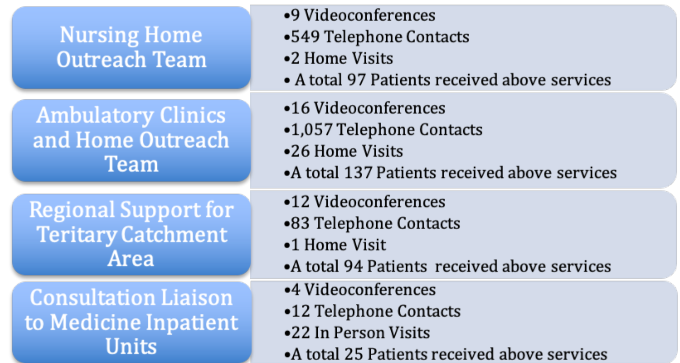

Figure 1. Raw Data from Geriatric Services at Parkwood Institute Mental Health

Indirect care was also completed through case-conferencing in order to support other health care providers in areas surrounding London-Middlesex County. There was an increase in consultation-liaison assessments, likely due to transfer of patients from the acute to subacute units during the start of the pandemic. The consultation service was re-organized and intensified to support this need.

Electroconvulsive therapy (ECT) had to be abruptly halted at first due to lack of readiness to provide infection control practices. To achieve this, the program was able to prioritize patients using recommendations from the International Society for ECT and Neurostimulation (ISEN). Patients were screened for COVID-19, treatment occurred in a negative pressure room to allow for appropriate air circulation and staff donned full PPE (Burhan, Safi, Blair, O'Reilly, 2020). Within a few weeks, ECT was restarted on those in the emergent and urgent categories (Burhan, Safi, Blair, O'Reilly, 2020). With frequent communication between the ECT team and the geriatric services described earlier, treatments were added or subtracted based on severity of cases.

Conclusions

During this unprecedented time, the geriatric population is one of the most susceptible groups. As such, we all need to be aware of this and help keep them safe. They are at risk of negative consequences, not only from COVID-19, but also from various restrictions which may cause negative psychological effects.

We need a comprehensive review of funding, staffing and training for long term care facilities in Canada in order to better support this population. Older adults should also receive assistance for engaging in virtual care assessments with health care providers, receiving safe in-home interventions as needed and continuing with public health and physical distancing measures to protect themselves. To balance the risk of transmission and the risk of functional decline from social isolation, it is important to prioritize and adjust the treatment of mental health issues that concern older adults and develop a better understanding of essential in-person visits.

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A COVID-19 Diary

Harry Kuhn

I am a writer who is recovering from a mental illness, schizophrenia, and coping with life during the pandemic. I live in an apartment building where every tenant has a mental illness. I act as a volunteer liaison between the management and the tenants and a representative for the tenants. They are all struggling with the pandemic as well. They often come to me with some of their issues and ask advice. Often, they come with problems that are the superintendent's area of responsibility and I pass that information on.

During my recovery from schizophrenia I have struggled with stigma, my awareness that it exists and that is common. Often, I anticipate a bad reaction if my mental illness becomes commonly known and so most times, I make no reference to it. I have been seeing a psychologist for over 20 years but not at all since the pandemic was declared. I have spoken to him once on the phone in the past 6 months. I have in that time begun journaling regularly when I am depressed or anxious.

Family losses, tenant issues…

In late January my oldest brother died suddenly. He and I were close and used to talk on the phone almost every day. I missed the contact, the conversations, and was still in a grieving state when the pandemic was declared. The pandemic closed down all of my social outlets. I belonged to a writer's group, which I facilitated, organized social hours twice a week with the tenants where I live, a monthly community meal with the same tenants, and attended a smoking cessation group. All of these outlets were cancelled as well as a more or less monthly visit with my long time best friend for coffee or a meal. I maintained my isolation as the government advised but felt the loneliness acutely at times.

In mid-June my second oldest brother died as well. It, too, was sudden and I had not been in touch with him since April. I felt the shock deeply and regretted that I had not had a chance to speak to him to say good-bye. During this time things were getting bad at the apartment building and I had tenants coming to me to ask for help with things that I had no control over. They expected me to do something about troublesome people in the building and vandalism etc... things beyond my ability and responsibility. The best I could do was keep the superintendent informed but it became stressful every time there was a knock at my door.

In mid-August my oldest sister Jean was diagnosed with terminal cancer. The doctors could not say how long she has but it could be any time. I felt saddened and overwhelmed for a while but have had several conversations with her since then and feel better now, although, I don't know how I will react to her passing. With pandemic restrictions and the fact that she is in another province there is no possibility of going to visit her.

Learning to cope

Over the past few years I have read a lot of material on Stoicism. I've read The *Meditations of Marcus Aureliu*s (translated by Gregory Hays, 2003 Modern Library Paperback Edition), *The Enchiridion and Selections from the Discourses of Epic*tetus (translated by George Long, 2005 A Digireads.com Book*), Letters from a Stoic by Seneca* (translated by Robin Alexander Campbell, 2014 Penguin Random House UK), and a couple of modern Stoic books by Ryan Holiday (*The Obstacle Is The Way*, 2014 Portfolio/Penguin; *Stillness Is The Key*, 2019 Portfolio/Penguin). I have been, for most of this year, keeping a journal where I write what is on my mind or troubling me and then give myself advice based on what I have learned in Stoicism. I

find that reaching more positive perspectives from my own thoughts has a tranquilizing effect on me and is a great help. I have considered the naturalness of death, that everyone, including me, will experience it and it is nothing to fear. Similarly, that the loss of someone close is not really a loss but a returning of a gift to the Giver and my focus should be on appreciating the time and experience I've had of the person. At other times I will make a list of all the things in my life that I don't control then a list of what I do control and try to focus my thoughts on what I do control. The reflections do not necessarily make me happy but give me some calm for periods of time. Below are some quotes from my journal.

26 January 20 (My brother Jim's death): *"It is natural to be emotional when a loved one dies. I shouldn't fear it. It is also natural that people die. Some day it will be my turn. I don't need to fear that either. All living things eventually die."*

13 June 20 (My brother Dan's death): *"Death is a part of life. It is natural and to be expected when old age and poor health combine. It is not a tragedy—it is the circle of life. He has returned to God and is okay."*

I am also a Catholic. I don't attend mass, but I do pray daily. I find my Stoic reflections go well with my faith. When I speak of returning a gift to the giver, I am thinking of returning someone to God from whom they came into my life. I rarely speak to people about my faith, hoping that instead I live it well enough for them to see it in my attitude and actions.

Healing through writing

Also, I am a writer. Since the pandemic I have not written much, but what I have written is more about my feelings than I used to write. Below is an example.

Steadfast Companions

The high pitched wail of a siren awakens me. Sleep, thick and heavy in my eyes as I try to see.
What an odd dream I had, all dead people, it seemed, but alive and well.
I'll tell Jim about it when I call him.
Suddenly I am wide awake and know that Jim is also dead; Dan too.
There is a pressure in my chest that is not physical and I clear my mind as I dress. I expected that as a matter of course, our ages being so far apart, I'd outlive them. But who expected them to go so suddenly and in such a short span of time?
I sip my morning coffee and think about the day ahead, a COVID day.
I could go for a walk; the coffee shops and restaurants are open now, but I stay clear of them.
Checking emails and Facebook doesn't lift my spirits.
Who can I phone for some pleasant, and distracting, conversation?
No one, really; it's all text messages these days.
A few years ago I had four brothers, three still at the beginning of this year.
Now I have one.
I have so much time to sit and think such thoughts and how distant I've grown from most family.
The downside of living alone.
This is nature running its course; my turn will come.
I pick up my book and turn to the marked page.
My steadfast companions.

Writing has helped me with my recovery in many ways. I've done numerous public readings of pieces about mental illness as well as a couple of regular stories. All of them have been well received. I've been published ten times and my confidence grows each time. Writing about personal experiences and finding that people identify with them and understand what I am talking about has brought me healing. My experiences of writing have not only brought healing, they accelerated the process for me. I had to overcome my fear of publicly admitting I have a mental illness. I dealt with the anxiety before each public reading and then mingled with people afterwards and found it was not the end of the world as I knew it. I grew in confidence in my ability to express myself and be understood, and also that my thinking was not 'crazy' and actually made sense to non- mentally ill people. I also learned, in writing about life experiences, that people identified with my experiences, that I had a lot in common with other people. This all changed my thinking about myself for the better and removed a lot of the depression I usually felt. As well, facilitating a writing group has encouraged me to speak freely in groups and built my confidence even more.

In sum…

For practical necessities, my niece has been grocery shopping for me and I don't take the city bus any more. I wear a mask to all of my appointments and stay home most of the time. The exceptions are when I can't avoid going to a store for something I've run out of. I dislike wearing a mask, don't like the way it feels or my glasses steaming up, but I follow the government guidelines. I ask tenants at the apartment building to stand back a bit when they come to my door.

The biggest challenge for me with the COVID-19 isolation has been the seclusion and the emotional impact it has had on me. Stoicism has been a big help in that area. It provides me with a way of thinking and understanding life around me and focusing on what I can do instead of what I cannot do. Phone calls, actually talking to people and not texting, are positive as well. They are not as good as face to face contact, but the conversation is helpful regardless of what is talked about. And of course, my spirituality is a constant positive. I will make it through the pandemic by being safe and being as positive as I can be. The things I have in place will help me to do that.