As the older adult inpatient population expands and increased attention is devoted to physical health, it is necessary to have mental health providers capable of providing age-specific services. Mental health staff are not typically trained to address the unique needs of older adults (Hoge, Karel, Zeiss, Alegria, & Moye, 2015; Karel, Knight, Duffy, Hinrichsen, & Zeiss, 2010). The lack of trained mental health staff serving older adults has been described as a workforce “crisis” (Eden, Maslow, Le, & Blazer, 2012; Lehmann, Brooks, Popeo, Wilkins, & Blazek, 2017). This crisis is due to the expanding population of older adults, a proportional increase in need for services, inadequate preparation of the mental health workforce, and lack of standardized training for providers on age-related issues. Required training in geriatrics for mental health staff has been suggested to address these problems (Bartels, 2003; Bartels & Naslund, 2013). The current article examines a staff training initiative to raise awareness of aging issues and improve communication with older adults, and describes a recent training series.

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BACKGROUND

There are few training programs designed to enhance the skills of mental health staff serving older adults (Cottingham et al., 2014; Maiden, Horowitz, & Howe, 2010). In addition, aging services do not typically provide training on communicating with individuals with severe mental illness. Conversely, nursing homes use training initiatives to improve nursing staff abilities to manage difficult behaviors related to age-onset depression and dementia, and research suggests training improves knowledge and skills needed to manage difficult behaviors (Blair Irvine et al., 2012; Spector, Revolta, & Orrell, 2016).

Older adults with severe mental illness have unique needs that must be addressed, including increased physical, cognitive, and functional disabilities. One difficulty when working with older adults with severe mental illness is communication. Older adults are at risk for sensory changes such as hearing and vision loss, which can increase symptoms of paranoia (Badcock, Dehon, & Lanzi, 2017; Zimbardo, Anderson, & Kabat, 1981). Such sensory impairments may increase risk for anxiety or depression in individuals with pre-existing severe mental illness. The natural effects of aging, including increased risk for health conditions and slower cognitive processing speed, are normal experiences of aging and should not be considered clinical conditions. However, normal aging processes may interact with symptoms of mental illness, medication side effects, and reduced access to health care, which can accelerate aging (Jeste, Wolkowit, & Palmer, 2011; Mathias et al., 2017). Communication skills are the foundation of all mental health interventions, and communicating effectively with individuals with hearing or vision loss requires a unique skill set. Communication techniques are essential for effective nursing interventions and nonpharmacological management of psychiatric symptoms (Eden et al., 2012). Psychiatric hospital nursing staff are not typically trained on how to communicate with older adults or challenges related to providing care for older adults.

Communication with older adults with mental illness may be difficult due to the complex interplay between increased likelihood of negative symptoms, executive processing challenges related to structural brain changes over time due to mental illnesses, natural age-related changes, health conditions, potential for dementia, effects of institutionalization, and long-term use of sedating medications (Jeste et al., 2011; Mathias et al., 2017). These factors may contribute to difficulty expressing needs, comprehending information, and responding to requests, as well as problems associated with executive thinking and memory. These factors can also impede development of effective therapeutic relationships.

Basic knowledge requirements for working with older adults with mental illnesses have been recommended (Eden et al., 2012; Lehmann et al., 2017), but proposed models have not yet been applied in inpatient mental health care settings or, specifically, by direct care workers. In addition to requiring assistance with psychiatric care, older adults in state psychiatric hospitals may require assistance with personal care. To assist with personal care, mental health staff working with older adults should understand cognitive and emotional aspects of aging, communication skills and strategies for improved interventions, and the impact of aging on the body.

Specialized skill training, which combines information about mental illness and aging, may teach staff members strategies necessary for improving communication with older adults with severe mental illness. This improvement in communication may improve staff–patient interactions and overall quality of life for individuals receiving care in state psychiatric hospitals.

METHOD

Because of a reorganization of state services, more than 100 older adults receiving services were transferred to a 450-bed state psychiatric hospital in the Northeastern United States over a period of 6 months. The hospital had not previously served large numbers of older adults. To respond effectively to its new population, hospital administration collaborated with a local university to develop a training program for nursing and rehabilitation staff to address knowledge gaps in working with older adults. Discussions with stakeholders identified challenges faced by the hospital in working with older adults. Based on these discussions, a 10-week training program was developed. Topics were selected based on staff needs and reflected the attitudes, knowledge, and skills recommended for geropsychological practice (Hoge et al., 2015; Knight, Karol, Hinrichsen, Qualls, & Duffy, 2009). In addition, the Pikes Peak Model of competencies in geropsychology (Knight et al., 2009) was used as a conceptual foundation for development of the curriculum. The model included attitudes of self-reflection of the aging process and awareness of ageist beliefs; knowledge of human developmental changes and how these changes impact activities of daily living, diagnosis overview, and strategies for effective positive interactions; and skills to improve communication and problem-solving in difficult interactions. These areas were further refined through discussion with nursing supervisors and nursing direct care staff to ensure application to nursing activities and adherence to philosophy of care.

General Training Strategy

The project was led by two consultants (M.Z., J.S.) employed full-time by a local university with offices at the psychiatric hospital. These consultants partnered with nursing staff to teach courses using interactive discussion, videos, experiential activities, and skills-training methods. The courses covered a variety of topics (Table 1).
Staff needs and preferences were determined through informal meetings with various stakeholders, including hospital administration, supervising nurses, direct care nursing staff, and treatment team members from four geriatric units. In addition, on-unit observation by consultants provided specific examples of staff challenges during interactions and challenging behavior from patients. Direct care staff also shared challenges they encountered working with individuals during the training sessions, and used examples to discuss problem solving. Trainers encouraged staff to ask questions, come prepared with examples, and explore problem-solving tactics.

Each weekly session was 1 hour in length and promoted psychiatric rehabilitation philosophies (i.e., focus on personal choice and methods to improve functioning in specific circumstances) with a positive aging and recovery-focused orientation. The weekly session combined the psychiatric rehabilitation aim of community integration and motivational strategies with a focus on normalizing the aging experience and strengths associated with positive aging. Staff were encouraged to view patients as capable of change from admission to discharge, and as individuals with hopes and dreams. Goals of the program included raising awareness of communication challenges and health conditions faced by the population, and introducing strategies to motivate and communicate with older adults.

Situational assessments throughout the training series helped staff understand patients’ behavior, as well as their strengths and weaknesses in regard to specific tasks or situations such as eating or bathing. Unlike a global functional assessment, a situational assessment of an older adult showering might assess the patient’s ability to perform specific steps of the task. For example, it may include assessment of the patient’s ability to independently undress, safely ambulate to the shower, hold a washcloth, and wash some or all parts of the torso. It was emphasized that older adults should be encouraged to be as independent as possible in all activities, and to accept the minimum support necessary if additional help from staff was needed.

The training program aimed to raise awareness and knowledge of difficulties that older adults with serious mental health conditions experience, and emphasize that normal experiences for this group include retirement, grandparenthood, and grieving, despite receiving inpatient psychiatric services. The program also raised awareness of physiological changes that interfere with activities of daily living and effective communication.

A total of 135 staff from day and evening shifts participated in the training.

| TABLE 1 |
|------------------|------------------|
| **DESCRIPTION OF MENTAL ILLNESS AND AGING TOPICS IN ORDER OF OCCURRENCE** |
| **Topic (Number of Sessions)** | **Description** |
| Overview of dementia (1) | Causes, diagnosis, brain changes, stages, communication deficits, and behavioral challenges. Comorbid dementia and pre-existing lifetime severe mental illness. |
| Challenges faced by older adults with mental illness (1) | Growth of the aging population and prevalence of mental illness in older adults. Summarized the complexity of medical comorbidity and bidirectionality of health and psychiatric symptoms. |
| Physical changes and aging (1) | Physical, sensory, and biological changes and impact of changes on behavior, functioning, and self-esteem. Included sensitivity activities to demonstrate impact of sensory loss. |
| Anxiety, depression, and self-harm in older adults (2) | Symptoms, risk factors, and interrelatedness of health issues in anxiety disorders in older adults. Prevalence and risk factors for depression in later life, including health consequences and treatment options. Suicide risk and steps to intervene. |
| Therapeutic communication strategies with older adults (2) | Communication difficulties related to psychiatric symptoms, aging, and cognitive impairments. Verbal and non-verbal communication techniques, and experiential skills for active listening and reflective responding. |
| Challenging behaviors and behavioral interventions (2) | Common challenging behaviors on geriatric units and environmental factors reducing aggression, anxiety, or verbal outbursts. Prevention of behavioral issues and de-escalation techniques. |
| Caregiver stress management and burnout prevention strategies (1) | Summarized key information managing caregiver stress. Relaxation training. |
Approximately 75% were direct care nursing staff. Communication techniques were emphasized throughout the training, including listening skills, non-verbal communication strategies, slower speech rates, reflective responding, and de-escalation techniques. Non-verbal communication strategies, such as hand gestures, body language, proximity, and visual aids, were presented as means to address impairments in hearing or language. Examples of behavioral challenges from units were used to emphasize the importance of understanding the influence of personal interactions on behavior, particularly regarding activities of daily living such as assistance with showering, personal care, and meals. The training included real-life examples of behavioral challenges identified during on-unit consultation, including combativeness during personal care, aggressive behavior toward staff and other service recipients, spitting, refusal to take medications, and elopement concerns.

RESULTS

Training surveys were solicited at the end of the 10-week training series. Participants who attended the final session were asked to complete an anonymous training evaluation to inform further development of the program. Survey results were combined, and common responses were condensed to a series of themes (Table 2). Staff self-reported changes in knowledge and behaviors following training, such as having more patience, placing greater emphasis on listening, and using multiple communication strategies. In addition, staff noted an increased understanding of dementia, mental illness, and techniques for managing difficult behavior. Staff also reported learning new skills to manage work burnout. After the training program, staff and nurs-
ing supervisors reported heightened awareness and understanding of needs of older patients in psychiatric hospitals. Finally, staff received additional support during training regarding difficult interactions, which encouraged self-reflection when working with older adults.

Staff found the problem-solving strategies during training helpful because the strategies offered concrete solutions for difficult care issues. Staff requested additional training in concrete strategies for provision of care and therapeutic techniques for older adults with mental illness. In addition, many staff members requested continued training and problem-solving rounds to address challenges of working with patients with complex psychiatric and medical issues.

Participants in this training series had little previous exposure to older adults, a shortcoming that may be similar to many mental health practitioners working in psychiatric inpatient settings. Trainers noted that staff members were appreciative of the opportunity to share frustrations, challenges, and successes during the training sessions.

CONCLUSION

Nursing staff working at psychiatric hospitals can benefit from specialized interprofessional training to improve understanding of aging processes and communication with older adults. The training initiative in the current article used didactic and experiential material to engage direct care staff, providing them with skill sets that were therapeutic and practical. As the population continues to age, future work should focus on developing manualized training and professional nursing education initiatives to train mental health practitioners in communication with, care of, and intervention strategies for older adults. In addition, future research should examine supervisory nursing oversight and feedback of new practices within state hospital systems following training initiatives to support staff behavior change.

REFERENCES


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