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Early Investigator Poster

needed more care outside their home. While nursing homes are tightly regulated on the federal level, ALFs are regulated by states and vary widely in their approaches to standards, procedures, and staffing.

Regardless of setting, community prevalence of mental illness, defined as “mental, behavioral, or emotional disorders,” is 14.1% in adults over 50. In addition, about 11% of people aged 65 and older in the United States have dementia. It is becoming increasingly important to monitor the prevalence of mental illness, including dementia, in ALFs, especially as the older adult population and ALF occupancy increase.

The aim of this review is to describe the prevalence of mental illness, including dementia, in Assisted Living residents, to detail existing models of mental health care for Assisted Living residents, and to discuss implications for clinical outcomes, health care utilization, and Assisted Living occupancy. For the purposes of this paper, dementia will be included under the rubric of “mental illness” due to its prevalence among Assisted Living residents, and the overlap of care delivery considerations with non-cognitive mental disorders.

Methods: This narrative review followed the best-practice recommendations outlined by Ferrari (2015). PubMed and Google Scholar were searched in June 2021 for the following key words: assisted living facility, psychiatric illness, limitations, hospitalization, discharge, and behavioral health integration, in addition to synonymous words related to three categories of interest including, prevalence of mental illness in ALFs, behavioral health care models in ALFs, and clinical outcomes of ALF residents. Articles were limited to the English language and to the United States or Canada. Emphasis was placed on recent systematic reviews and randomized controlled trials. All articles were initially screened according to title and abstract and were retained if they contained information on prevalence of mental illness in ALFs, behavioral health care models in ALFs, or clinical outcomes of ALF residents. Reference lists were hand-searched for additional research articles.

Results: Many articles reported various rates of mental illness and cognitive disorders in ALFs, however, the prevalence remains high and continues to increase as the older adult population increases. Across articles, prevalence of non-cognitive psychiatric disorders in ALFs ranged from 26% to 33% depending on methodology and study population. Prevalence of cognitive disorders in ALFs range widely depending on the type of facility: some ALFs admit exclusively persons with dementia, whereas other ALF facilities specialize in residents with fewer functional impairments. Studies have demonstrated that both depression and dementia in ALF residents are more prevalent when compared with community-dwelling controls. Behavioral health problems and high health care needs of ALF residents are common reasons for ALF discharge. Integrated models, which bring together specialty behavioral health care providers with health and supportive service providers, have been shown to reduce behavioral health symptoms and contribute to improved health of residents, improve care, and decrease associated care costs including staff turnover.

Conclusions: This narrative review addresses the importance of behavioral health needs in ALF residents. Articles identified limitations in ALF infrastructure and research, specifically relating to data collection and varying definitions of terms, which limits the generalizability of the results. Greater attention to the study, design, and implementation of behavioral health care for ALF residents may reduce the prevalence of distressing symptoms in those with psychiatric and cognitive disorders, and in turn decrease the need for unnecessary Emergency Department visits, hospitalizations, and premature facility discharge. Future research should consider measuring the effectiveness of mental health care in ALFs since there is limited research currently available.

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DEVELOPING A NEW SUICIDE RISK ASSESSMENT FOR VIRTUAL ENCOUNTERS WITH NON-CLINICIANS

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Introduction: The COVID-19 pandemic has necessitated that many research encounters be conducted virtually. Non-clinician staff (e.g. research assistants (RAs), study coordinators, or research trainees) with varying levels of clinical training and experience are typically the primary point of contact for research participants. Consequently, they are often the first to encounter suicidality. This highlights the need for robust virtual suicide risk assessment procedures that are at an appropriate level for research staff *and* optimized for remote clinical research visits. The current procedures for in-person visits conducted by the Geriatric

Psychiatry Program at McLean Hospital require non-clinician staff to complete the full Columbia Suicide Severity Rating Scale (CSSRS) in situations of active suicidal ideation (SI) before requiring clinician notification and intervention. However, staff and clinicians both reported that the virtual visit format limited the quality of the assessment and the ability to respond rapidly in situations of passive suicidal ideation, especially when this ideation did not meet the threshold for clinician notification specified in the in-person protocol. Thus, we established the need for a specific virtual suicide risk assessment protocol. Here we present our process for needs assessment and its findings, which in turn have shaped our revised protocol.

Methods: We surveyed clinicians and social workers affiliated with the Geriatric Psychiatry Research Program at McLean Hospital. The first goal of this survey was to collect information on how clinicians respond to situations of suicidality during telehealth assessments, and how clinicians recommend that staff navigate these situations in a virtual research setting. The second goal was to gather qualitative data that would guide preparatory safety planning (PSP) that non-clinician staff could complete prior to research visits. Because there are no standardized instruments for the information we wanted to collect, we developed a survey based on consensus among research staff.

Results: Of the 19 clinicians surveyed, 11 completed the brief survey. Nine (81.8%) of the eleven clinicians that responded had needed to deal with a patient at imminent risk of suicide in any setting. Only three (27.27%) clinicians were fully comfortable using the in-person SI protocol for virtual encounters. All 11 (100%) of responding clinicians conveyed that PSP should include information on (a) the exact location of the patient's home, (b) contact information for friends and family, and (c) an assessment of firearm access. The PSP should be completed as early as feasible in the research process, prior to formal enrollment, even if there was no reason to suspect SI at the time. Additional qualitative feedback included recommendations for lowering the threshold for enacting the SOP from subjects expressing active SI to passive SI to facilitate earlier intervention. Clinicians also recommended training staff on formal assessment measures such as the combined SAFE-T (Suicide Assessment Five-step Evaluation and Triage) and CSSRS protocol in a structured interview so that they could conduct a more systematic assessment if passive SI was reported.

Conclusions: As more research encounters are conducted virtually, protocols designed for in-person assessment of suicide risk must be adapted. We found that the most useful addition to a virtual SI protocol may be to lower the threshold for action from active to passive SI and inclusion of PSP. Our findings also indicate that staff should be trained in standardized suicide assessment and that there should be a low threshold for conducting these assessments (i.e. passive ideation) and notifying clinicians. Our findings may be broadly generalizable to all mental health research settings that involve virtual assessment by non-clinician staff.

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GAMIFICATION FOR GERIATRIC MENTAL HEALTH: LEVEL UP OR GAME OVER?

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Introduction: Gamification, or the incorporation of game-like elements in non-game contexts to support or develop specific behaviors has been a recent major trend in technology. Promising results regarding its effectiveness to promote healthful behaviors have been shown in multiple studies. However, much of the prior research has been focused on younger adults or for non-mental health indications in Older Adults. Our aim in this study is to assess existing evidence to guide Gamification approaches for geriatric mental health.

Methods: Given the heterogeneity of approaches that comprise Gamification, we elected to conduct a narrative literature review. We conducted a literature search in Google Scholar, PubMed, and the references of existing literature to identify a broad suite of papers on this topic. The search terms we utilized were "Gamif*", "Mental health", "Older adult", "Geriatric", and "Therap*".

Results: The number of studies focused on gamification and geriatric mental health is low, however current research does show some possible effectiveness for older adults. Previous studies have shown some efficacy in engagement with activation therapy for sub-threshold depression, motivational enhancement, self-sufficiency, improved resilience, and enhancing adherence to therapy.