

Attachment 1

PSYCHOLOGY IN AGED CARE: A Review of Evidence on the Effectiveness of Psychological Interventions

Introduction

There is universal agreement that Residential Aged Care Facilities (RACFs) are under increasing pressure from an ageing population. Compounding this problem are the difficulties experienced by residents of RACFs in accessing allied health service providers due to the separation of funding between most health services and aged care services. As a result, competently administered psychological assessments and a range of evidenced-based interventions by psychologists that are shown to decrease health service demand, improve quality of life and markedly decrease disruptive features among this client population are not available to residents. Examples of such interventions from psychologists include:

- Work in collaboration with medical staff in the accurate diagnosis of mental health or neurological conditions;
- Non-drug interventions for behaviour management that can be less disruptive and just as effective as medication;
- Strategies for better understanding, management and potential prevention of disruptive behaviour by RACF staff.

It is also important to recognise and understand that there is an extensive literature showing that staff in RACFs, who routinely undertake extremely difficult and emotionally fraught care tasks, are often stressed and relatively unsupported, which in turn affects quality of care (Edberg et al., 2008; Evers, Tomic, & Brouwers, 2002; Moniz-Cook, Woods, & Gardiner, 2000). Psychologists and psychological interventions are ideally positioned to also address these issues in care.

High prevalence of mental health disorders in RACFs

The incidence of psychological disorders is at much higher rates in RACFs than in the community (Rovner et al., 1990; Seitz, Purandare, & Conn, 2010). There have been several studies into the mental health status and well-being of older adults who are residing in long-term care facilities. In one study, prevalence of any psychiatric illness was 76.3 percent at admission to a RACF (Wancata, Benda, & Hajji, 1998). After dementing conditions, depression and anxiety are probably the most common psychiatric conditions in nursing home residents (e.g. Smalbrugge et al., 2005a). Estimates of the rate of major depression range from 6 percent to 24 percent, and for minor depression and dysthymia the estimates rise substantially to between 30 percent and 50 percent (Hyer et al., 2005). Furthermore, comorbidity with dementia is common (Hyer et al.). Anxiety symptoms have been estimated at approximately 30 percent of nursing home samples (Smalbrugge et al., 2005b). One study in Australian residential care

facilities has found the prevalence of depression was 32 percent (Anstey, von Sanden, Sargent-Cox, & Luszcz, 2007). All of these researchers have suggested that risk assessment and targeting of intervention strategies to prevent and treat depression and anxiety in late life, and in RACFs in particular, should be a priority and should target improving functional capacity and well-being areas in which psychologists are well-placed to offer their expertise.

Importance of accurate assessment and diagnosis

Correct diagnosis of psychological disorders is of vital importance, yet it is not always easy to obtain. Perhaps the main challenge for accurate assessment is the fact that multi-morbidity (when a person has two or more mental and/or physical health conditions) is very common, if not the norm (Hyer et al., 2005). Multiple illnesses, conditions and deterioration in cognitive functioning can make determining or deciding on which symptoms belong to which disorder extremely complicated. Additionally, competent use of diagnostic and assessment instruments and valid interpretations of the results are crucial to developing treatment plans that respond to a person's needs. For example, one of the most frequently used measures of cognition that informs decisions regarding medication for people with dementia is the Mini-Mental State Examination (MMSE) (www.pbs.gov.au). It is recognised that people not trained in the administration of the MMSE can inadvertently or unwittingly affect the results and scoring of the test; thus increasing the chance of under- or over-estimating the level of cognitive impairment, and in turn affecting treatment decisions. Misdiagnosis through inappropriate administration of MMSE is less likely to occur with proper training of physicians and others who administer the test. Such training should be provided by experts in the field who are familiar with the test – for example, neuropsychologists, who are well versed in methods of cognitive assessment. This training will lead to reduced rates for misdiagnosis, and subsequently decrease the risk of medication being prescribed inappropriately.

Treatments for mental disorders and challenging behaviours in RACFs

Currently, problems with mood, anxiety and challenging behaviours are commonly treated with psychoactive medication. Psychoactive medication is expensive, frequently has undesirable side effects and requires regular adjustment in order to deal with issues relating to poly-pharmacy. In addition to pharmacological interventions for mood and behaviour problems, there is increasing evidence for the effectiveness of psychological and other non-pharmacological interventions (e.g., Davison et al., 2007; Powers, 2008). Psychological interventions that are used in RACF's include, for example, Behavioural Activation, Cognitive Behavioural Therapy, Cognitive Therapy, Reminiscence Therapy and these therapies combined with medications. It is, however, also frequently observed that there is an absence of evidence to determine whether many interventions, specifically applied in the RACF context, are effective (e.g., Cameron et al., 2010; Hackett, Anderson & House, 2004).

The following section is a brief discussion examining the issues of: risks associated with no treatment; the acceptability of treatments for older people with depression; pharmacological and psychological interventions for challenging behaviours; and psychological interventions for depression, anxiety and falls.

Risk of no treatment

It is clear that the consequences of a lack of adequate psychological services for older adults can be profound. For example, a recent study in the UK found that 80 percent of older adults who completed suicide had not engaged with any mental health services and 15 percent completed suicide while under the care of a psychiatrist (Salib, & El-Nimir, 2003). Osvath, Fekete, and Voeroes (2002) had reported similar findings and highlighted the result that older people who attempted and/or completed suicide were more likely to have undiagnosed depression. They state: "the recognition and treatment of depression plays a very important role in suicide prevention in the elderly population, and adequate emotional and psychosocial support by family and health care systems seems to be essential" (p.3).

Treatment acceptability

A study by Hanson and Scogin (2008) examined the issue of what types of treatments were considered most acceptable for treating depression in older people in the general community. Interestingly, for mild to moderate depression, cognitive therapy was viewed as being more acceptable than medicine alone or in combination with cognitive therapy. However, for severe depression, cognitive therapy combined with medicine and cognitive therapy alone were perceived as more acceptable treatments than antidepressants only.

Pharmacological and psychological treatments for challenging behaviours

When pharmacological treatment is supplied for behavioural disturbances, which are very common in residential care, the medications used are frequently inappropriate or ineffective (Ramadan, Naughton, & Prior, 2003). Meta-analyses over the last two decades have repeatedly shown that anti-psychotics, the most common intervention, have modest efficacy at best and frequent side-effects (Schneider, Pollock, & Lyness, 1990; Schneider et al., 2006; Sink, Holden & Yaffe, 2005). Psychosocial interventions for challenging behaviours in aged care services, however, are shown to be effective (Bird, Llewellyn-Jones, Smithers & Korten, 2007; Cohen-Mansfield, 2003; Opie, Rosewarne, & O'Connor, 1999), do not have the risks of side-effects, avoid poly-pharmacy issues and cost significantly less than conventional pharmacological forms of treatment.

An Australian, multidisciplinary trial funded by the Commonwealth Government compared the effectiveness of tailored, personal psychosocial interventions for challenging behaviours (the intervention group) with treatment as usual (control group; Bird, Llewellyn-Jones, Smithers & Korten, 2002). In the intervention group, psychotropic medication was still used in a minority of cases, but most participants received a mix of psychosocial interventions tailored to their needs. Over the course of the trial, only one participant in the intervention group was hospitalised (for a total of two days) compared with more than 20 percent (total hospital days 93) of the participants in the control group which was treated mainly with anti-psychotics. Drug side-effects were reported in 32 cases in the conventional treatment group and in 12 cases in the psychosocial group - representing a threefold reduction. Additionally, visits by general practitioners to deal with behavioural problems were reduced by half, to an average of 4.5 visits in the psychosocial group, compared with 9.4 visits in the conventional treatment group. Visits by consultant psycho-geriatricians were also less common, with an average of 1.2 visits in the psychosocial group, as against 4.8 visits in the conventional care group. Use of anti-psychotics declined in the psychosocial group and increased in the control group. Thus this study

illustrates the range and scale of the benefits to be gained by utilising psychosocial interventions appropriately.

Similar trials are now being reported in the international literature (Bird, Llewellyn-Jones, Smithers & Korten, 2007; Cohen-Mansfield, Libin & Marx, 2007; Davison et al., 2007a; Fossey et al., 2006). This person-specific approach is essentially the method advocated by the Commonwealth Government in the Dementia Behaviour Management Advisory Services programme (DBMAS).

Contributions by specialist psychologists in aged care can also lead to improved overall cost-effectiveness of interventions through decreased reliance on medications, or their more focussed use.

Psychological interventions for older people with mental and physical conditions

The evidence base for psychological interventions applied and or tested specifically in RACF is relatively small but growing (Powers, 2008). However, much of the foundations for which psychological interventions are being applied in RACFs comes from the research literature testing psychological interventions when utilised by older people living in the general community. It is recognised that older people living in the community represent a substantially different group of people compared with older people living in RACFs who typically have more frequent and more severe mental and physical health conditions (Seitz, Purandare, & Conn, 2010). Psychological interventions and services have been shown to be efficacious and cost-effective with older adults (in the general community) for conditions such as depression (Cuijpers, van Straten & Smit, 2006; Scogin & McElreath, 1994; Leff et al., 2000); anxiety (Koder, D. A., 1998; Weatherell, 2002; Pachana, Woodman & Byrne, 2007); incontinence (Burgio, 1998) and chronic pain (Cook, 1998). One US study found that every dollar spent on psychological treatment for chronic pain led to a five dollar saving in medical costs (Gonick, Farrow, Meier, Ostmand, & Frolick, 1981). Recommendations for the management of pain in residential care facilities are being prepared by the Australian Pain Society and these include non-pharmacologic treatments (www.apsoc.org.au/pdfs/Draft1APSRACPMG.pdf).

Psychological interventions for older people with chronic conditions

Many chronic physical conditions interfere with both current medical treatment and impair the quality of life of those with such conditions. Psychological services can be of substantial benefit in these cases by addressing some of the underlying factors or by assisting in minimising the psychological impact of such chronic conditions. For example, a study examining stress management techniques for people with hypertension found that following treatment over 50 percent of people managed their symptoms well and without the need for medication. The average total medical costs saved per person over a five-year period was over US\$1300 (Fahrion, Norris, Green & Schar, 1987).

In another study of 700 participants with heart disease, hypertension and diabetes who were also receiving psychological services were tracked for a three-year period and compared to a group of 1300 patients who did not receive psychological treatment. Those participants who received psychological treatment showed a 40 percent reduction in annual medical costs when compared to patients who were not given psychological services. Once the cost of psychological intervention was taken into account there was still a 5 percent net saving (Schlesinger, Mumford, Glass, Patrick, & Sharfstein, 1983).

Psychological interventions for older people with depression

A meta-analysis (Cuijpers, van Statén, & Smit, 2006), and systematic reviews (e.g. Scogin et al., 2005) have demonstrated overall support for the use of psychological interventions for the treatment of depression in community living adults. However, as mentioned previously, there is a general lack of research examining the efficacy of psychological interventions with people living in RACFs. One recent study (Snarski et al., 2010), however, recruited 50 participants living in an RACFs who were at least 65 years of age, with mild to moderate cognitive impairment. Participants were either allocated to the treatment as usual group or the behavioural activation group for treatment of depression. The behavioural activation group engaged in four, weekly, 60-minute sessions. Snarski et al. found the behavioural activation to be effective early in the treatment. Importantly, they also found that cognitive functioning was not related to the effectiveness of the intervention. Yon and Scogin (2009) also demonstrated in a small study (n=9) that behavioural activation can be an effective form of treatment for depression in older people (mean age = 75 years) living in the community. A similar study by Karimi et al. (2010) examining the effectiveness of reminiscence therapy (Butler, 1963) for treating depression in older people in nursing homes found support for its efficacy. (Reminiscence therapy was designed as a form of therapy specifically for older people and is a structured process of systematically reflecting on one's life and examining the thoughts and feelings associated with significant, unresolved events.)

Other studies have found that both cognitive therapy and cognitive bibliotherapy for depression in older people living in the community to be effective up to two years after the intervention was completed (Floyd et al., 2004; Floyd et al., 2006). Conversely, Hackett, Anderson and House (2004) in a Cochrane Review concluded that there was insufficient evidence for the use of either anti-depressants or psychotherapy in the treatment of depression in older people following a stroke. Their conclusion was based on data that revealed a lack of standard diagnostic and outcome criteria, and differing analytic methods used by investigators.

Psychological interventions for older people with anxiety disorders

The effective treatment of anxiety disorders in older adults in RACFs is recognised as an area of research that is underdeveloped (Wetherell, Sorrell, Thorp, & Patterson (2005). Wetherell et al. reviewed randomised controlled trials for psychological interventions for anxiety disorders in older people and concluded that evidence existed for the efficacy of relaxation training for subjective anxiety symptoms, and cognitive behavioural therapy for generalised anxiety disorder and panic disorder with/without agoraphobia.

Psychological interventions for falls prevention

Cameron et al. (2010) completed a Cochrane Review of interventions for preventing falls in older people. They concluded that multifactorial interventions, typically provided by multi-disciplinary teams including psychologists are effective in reducing falls and risk of falls in hospitals and may do so in RACFs. Psychological interventions typically involved addressing anxiety (e.g. especially fears about falling), comorbid mood disorders and adjustment issues associated with changes in functioning that have occurred.

Psychological interventions for caregivers of people with dementia

Selwood et al. (2007) completed a systematic review of the literature examining efficacy of interventions that support people who care for people with dementia. Given that there are many risks associated with caring for a person living with dementia (e.g. increased risk of developing psychological morbidity), supporting the carer is considered vital to ensuring a standard of care is provided in RACFs. The review concluded that although there were only 10 studies identified, there was strong evidence supporting individual behaviour management therapy. Significantly, the intervention effects were evident up to 32 months follow-up.

Conclusion

Given the nature of Australia's ageing population, the disproportionately high prevalence of multi-morbidity that exists in older people living in RACFs, and the relative lack of high quality research investigating psychological intervention in RACFs, this area should be made a research priority as a matter of urgency. Based on research conducted with older people living in the community, there is much to suggest that there might be many efficacious psychological interventions for treating mental disorders (e.g. behavioural activation for depression in older people with cognitive impairment), challenging behaviours and the stress of caring for people with dementia. However, much more research needs to be done to determine what strategies work best, with whom, in what combination with medicine, and what works best for Indigenous people and people from culturally and linguistically diverse backgrounds.

References

- Anstey, K. J., von Sanden, C., Sargent-Cox, K., & Luszcz, M. A. (2007). Prevalence and risk factors for depression in a longitudinal, population-based study including individuals in the community and residential care. *American Journal of Geriatric Psychiatry, 15*, 497-505.
- Bird, M., Llewellyn-Jones, R., Smithers, H., & Korten A. (2002). *Psychosocial approaches to challenging behaviour in dementia: A controlled trial. Report to the Commonwealth Department of Health and Ageing: Office for Older Australians*. Canberra, ACT.
- Bird, M., Llewellyn-Jones, R., Korten, A., & Smithers, H. (2007). A controlled trial of a predominantly psychosocial approach to BPSD: Treating causality. *International Psychogeriatrics, 19*(5), 874-891.
- Burgio, K. L. (1998). Behavioral vs. drug treatment for urge incontinence in older women: A randomized controlled trial. *Journal of the American Medical Association, 280*, 1995-2000.
- Butler, R.N., 1963. *The life review: an interpretation of reminiscence in the aged*. *Psychiatry 26* (1), 65–76
- Cameron, I.D., Murray, G.R., Gillespie, L.D., Robertson, M.C., Hill, K.D., Cumming, R.G., Kerse, N. (2010) Interventions for preventing falls in older people in nursing care facilities and hospitals. Cochrane Database of Systematic Reviews 2010, Issue 1. Art. No.: CD005465. DOI: 10.1002/14651858.CD005465.pub2
- Cohen-Mansfield, J. (2003). Nonpharmacologic interventions for psychotic symptoms in dementia. *Journal of Geriatric Psychiatry and Neurology, 16*, 219-224.
- Cohen-Mansfield, J., Libin, A., & Marx, M.S. (2007). Non-pharmacological treatment of agitation: a controlled trial of systematic individualized intervention. *The Journal of Gerontology, 62A*, 908-916.
- Cook A. J. (1998). Cognitive-behavioral pain management for elderly nursing home residents. *Journal of Gerontology, 53B*, 51-59.
- Cuijpers, P., van Straten, A., & Smit, F. (2006). Psychological treatment of late-life depression: A meta-analysis of randomized controlled trials. *International Journal of Geriatric Psychiatry, 21*(12), 1139-1149. doi:10.1002/gps.1620
- Davison, T.E., Hudgson, C., McCabe, M.P., George, K., & Buchanan, G. (2007). An individualized psychosocial approach for treatment resistant behavioural symptoms of dementia among aged care residents. *International Psychogeriatrics, 19*(5), 859-873.
- Fahrion, S., Norris, P., Green, E., & Schnar, R. (1987) Behavioral treatment of hypertension: A group outcome study. *Biofeedback and Self-Regulation, 11*, 257-278.
- Fossey, J., Ballard, C., Juszczak, E., James, I. A., Alder, N., Jacoby, R., & Howard, R. (2006). Effect of enhanced psychosocial care on antipsychotic use in nursing home residents with severe dementia: Cluster randomised trial. *British Medical Journal, 332*, 756-758.

Floyd, M., Scogin, F., McKendree-Smith, N. L., Floyd, D. L., & Rokke, P. D. (2004). Cognitive Therapy for Depression: A comparison of individual psychotherapy and bibliotherapy for depressed older adults. *Behavior Modification, 28*(2), 297-318.

Floyd, M., Rohen, N., Shackelford, J. M., Hubbard, K. L., Parnell, M. B., Scogin, F., & Coates, A. (2006). Two-Year Follow-Up of Bibliotherapy and Individual Cognitive Therapy for Depressed Older Adults. *Behavior Modification, 30*(3), 281-294.

Gonick, U., Farrow, I., Meier, M., Ostmand, G., & Frolick, L. (1981). Cost effectiveness of behavioral medicine procedures in the treatment of stress-related disorders. *American Journal of Clinical Biofeedback, 4*, 16-24.

Hackett, M., Anderson, C., & House, A. (2004). Interventions for treating depression after stroke. *Cochrane Database Of Systematic Reviews*, <http://www2.cochrane.org/reviews/en/ab003437.html> accessed 28 March 2011.

Hanson, A. E., & Scogin, F. (2008). Older adults' acceptance of psychological, pharmacological, and combination treatments for geriatric depression. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 63B*(4), 245-248.

Hyer, L., Carpenter, B., Bishmann, D., & Wu, H.-S. (2005). Depression in long-term care. *Clinical Psychology: Science and Practice, 12*, 280-299.

Karimi, H. H., Dolatshahee, B. B., Momeni, K. K., Khodabakhshi, A. A., Rezaei, M. M., & Kamrani, A. A. (2010). Effectiveness of integrative and instrumental reminiscence therapies on depression symptoms reduction in institutionalized older adults: An empirical study. *Aging & Mental Health, 14*(7), 881-887.

Koder, D. A. Treatment of anxiety in the cognitively impaired elderly: Can cognitive-behavior therapy help? *International Psychogeriatrics 10, 173-182. 1998.*

Leff, J., Vearnals, S., Brewin, C. R., Wolff, G., Alexander, B., Asen, E., Dayson, D., Jones, E., Chisholm, D. & Everitt, B. (2000). The London Depression Intervention Trial. Randomized controlled trial of antidepressants v. couple therapy in the treatment and maintenance of people with depression living with a partner: Clinical outcome and costs. *British Journal of Psychiatry, 177*, 95-100.

Moniz-Cook, E., Woods, R., & Gardiner, E. (2000). Staff factors associated with perception of behaviour as 'challenging' in residential and nursing homes. *Aging and Mental Health, 4*, 48-55.

Opie, J., Rosewarne, R., & O'Connor, D. W. (1999). The efficacy of psychosocial approaches to behaviour disorders in dementia: A systematic literature review. *Australian and New Zealand Journal of Psychiatry, 33*, 789-799.

Osvath, P., Fekete, S., & Voeroes, V. (2002). Attempted suicide in late life: Review of results of Pecs Centre in WHO/Euro Multicentre Study of Suicidal Behaviour. *Psychiatria Danubina, 14*, 3-8.

Pachana N.A., Woodman, R., Byrne, G.J.A. (2007). Treatment of specific phobia in older adults. *Clinical Interventions in Aging, 2*(3), 469-476.

- Powers, D. V. (2008). Psychotherapy and long-term care: II. Evidence-based psychological treatments and other outcome research. *Professional Psychology: Research and Practice*, 39, 257-263.
- Ramadan, F. H., Naughton, B. J., & Prior, R. (2003). Correlates of behavioral disturbances and pattern of psychotropic medication use in five skilled nursing facilities. *Journal of Geriatric Psychiatry and Neurology*, 16, 8-14.
- Rovner, B. W., German, P. S., Broadhead, J., Morriss, R. K., et al. (1990). The prevalence and management of dementia and other psychiatric disorders in nursing homes. *International Psychogeriatrics*, 2, 13-24.
- Salib, E., & El-Nimr, G. (2003). Utilization of psychiatric services in elderly suicide. Analysis of coroner's inquests of 200 cases of elderly suicide in Cheshire 1989-2001. *International Journal of Psychiatry in Clinical Practice*, 7, 121-125.
- Schlesinger, H. J., Mumford, E., Glass, G. V, Patrick, C., & Sharfstein, S. (1983). Mental health treatment and medical care utilization in a fee-for-service system: Outpatient mental health treatment following the onset of a chronic disease. *American Journal of Public Health*, 73, 422-429.
- Schneider, J.F., Pollock, V.E., & Lyness, A. (1990). A meta-analysis of controlled trials of neuroleptic treatment in dementia. *Journal of the American Geriatrics Society*, 38, 553-563.
- Schneider, L., et al. (2006). Effectiveness of atypical antipsychotic drugs in patients with Alzheimer's Disease. *The New England Journal of Medicine*, 355, 1525-1538.
- Scogin, F., & McElreath, L. (1994). Efficacy of psychosocial treatments for geriatric depression: A quantitative review. *Journal of Consulting and Clinical Psychology*, 62, 69-74.
- Scogin, F. Welsh, D., Hanson, A., Stump, J. & Coates A. (2005) Evidence-based psychotherapies for depression in older adults. *Clinical Psychology: Science and Practice*, 12, 222-237.
- Seitz, D., Purandare, N., & Conn, D. (2010). Prevalence of psychiatric disorders among older adults in long-term care homes: A systematic review. *International Psychogeriatrics*, 22(7), 1025-1039.
- Selwood, A., Johnston, K., Katona, C., Lyketsos, C., Livingston, G. (2007) Systematic review of the effect of psychological interventions on family caregivers of people with dementia. *Journal of Affective Disorders* 101(1-3), 75-89.
- Sink, K.M., Holden F.H., & Yaffe, K. (2005). Pharmacological treatment of neuropsychiatric symptoms of dementia: a review of the evidence. *Journal of the American Medical Association*, 293, 596-608.
- Smalbrugge, M., Jongenelis, K., Pot, A.M., Beekman, A.T., & Eefsting, J.A. (2005a). Comorbidity of depression and anxiety in nursing home patients. *International Journal of Geriatric Psychiatry* 20, 218-226.
- Smalbrugge, M., Pot, A.M., Jongenelis, K., Beekman, A.T., & Eefsting, J.A. (2005b). Prevalence and correlates of anxiety among nursing home patients. *Journal of Affective Disorders*. 88, 145-153.

Snarski, M., Scogin, F., DiNapoli, E., Presnell, A., McAlpine, J., & Marcinak, J. (2010). The effects of behavioral activation therapy with inpatient geriatric psychiatry patients. *Behavior Therapy, 42*(1), 100-108.

Wancata, J., Benda, N., & Hajji, M. (1998). Prevalence and course of psychiatric disorders among nursing home admissions. *European Psychiatry, 13, Supplement 4*, 273-273.

Wetherell, J. L. (2000). Behavior therapy for anxious older adults. *Behavior Therapist, 25*, 16-17.

Wetherell, J., Sorrell, J. T., Thorp, S. R., & Patterson, T. L. (2005). Psychological interventions for late-life anxiety: A review and early lessons from the CALM Study. *Journal of Geriatric Psychiatry and Neurology, 18*(2), 72-82.

Yon, A., & Scogin, F. (2009). Behavioral activation as a treatment for geriatric depression. *Clinical Gerontologist: The Journal of Aging and Mental Health, 32*(1), 91-103.

Additional resources

APS ethical guidelines for the provision of psychological services for, and the conduct of research with older adults.

<http://www.psychology.org.au/Assets/Files/EG-Older-adults.pdf>

American Psychological Association guidelines for working with older adults:

<http://www.apa.org/practice/guidelines/older-adults.pdf>

Australian Pain Society

<http://www.apsoc.org.au>