Didactic Presentation: Role of a Psychologist in Residential Aged Care & Research Overview

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Presentation Overview

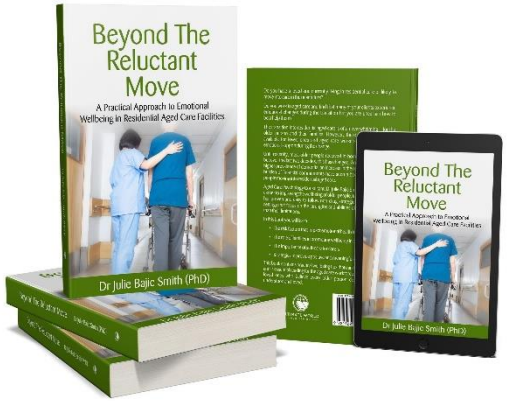
1. Statistics – what we know about mental illness in RACFs
2. Pulling apart comorbidities
3. Escalation of wellbeing concerns
4. What works with older adults
5. Meet Jim and Elaine
6. Research Overview – Emotional and Psychological Wellbeing in Workforce

About The Presenter

- Wise Care is Australia's leading aged care mental wellbeing training provider.
- Founder – Julie Bajic Smith
  - **Qualified** – PhD with research thesis in optimising aged care mental wellbeing.
  - **Experienced** - over a decade of clinical experience.
  - **Passionate and determined** - to support you to implement positive change.

About The Presenter

- Range of free resources available from wisecare.com.au
- Book *"Beyond the Reluctant Move"*
- Industry endorsed workshops:
  - Grief and Loss in Late Life (2 hr)
  - Enhancing Emotional Wellbeing in Late Life (6 hr)
  - Supporting Elders During the Pandemic (6hr)



wisecare.com.au/book

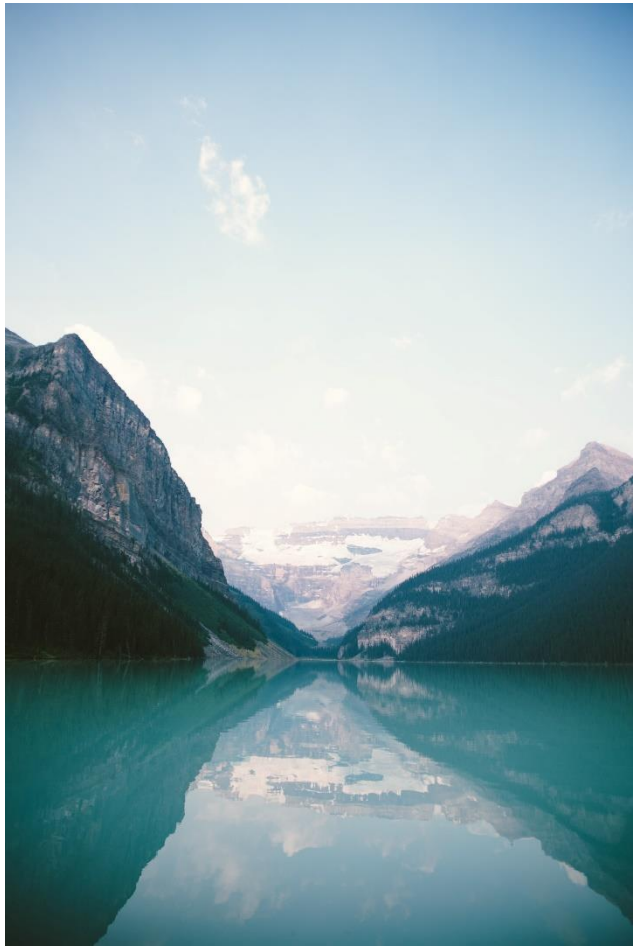
Meet Jim and Elaine

- Jim and Elaine moved into a RACF after their son went on holidays. Initially told it was respite but their stay was always intended to be permanent.
- Jim has a history of depression, which was never treated but he kept occupied in his garden and catching up with two church friends. He is now isolating in his room, refusing to come out, apart for meals, as Elaine makes him attend. Feels angry with his son.
- Elaine has a history of GAD, never treated and always saw herself as being “a worrier”. She worries about Jim and his health in the new environment and constantly seeks reassurance from staff. Elaine is experiencing early stages of dementia.

Protective Factors in Late Life

- personal attributes
- physical health and healthy behaviours
- physical activity levels
- social support and inclusion
- strong cultural identity and pride

Why Explore Mental Illness(es)?



Because they are often

a) overlooked
b) underdiagnosed
c) treatable.

When Referrals Are Made

- Older person experiencing difficulty adjusting to environment and requires counselling
- Older person presents with symptoms of depression/anxiety
- Initial one off assessment made by facility
- Family requesting support for their loved one
- Critical incident

Overview - Depression

- According to AIHW (2018) up to 1 in 2 residents present with symptoms of depression
- Depression is routinely screened using Cornell Scale for Depression in Dementia (part of ACFI Instrument)
  - Limited implications for higher scores
    - When concerns are escalated to GPs (including suicidality)
    - When and if scores are revisited
    - What is done on-site to assist clients

Depression in Late Life

- Often masked by other health conditions
- Poorly detected, diagnosed and treated
- Older people are more comfortable reporting pain and physical symptoms which may be depression.
- Normalised as part of ageing
- Older adults may not necessarily have a past history of depression in earlier life.

Anxiety in Late Life

- More than feeling stressed.
- Different to our normal reaction to everyday events.
- Experiencing:
  - physical symptoms (sweating, difficulty sleeping)
  - changes in feelings (sudden intense panic)
  - behavioural changes (avoidance, impaired concentration)
  - changes in thinking styles (constant worrying).
- Clients usually have a past history of anxiety.

Overview - Anxiety

- Anxiety is not routinely screened and is less researched
- High prevalence of anxiety in RACF up to 60% of residents display symptoms (Creighton et al, 2016)
- High co-morbidity between anxiety and depression: anxiety affects outcome of treating depression and increases relapse (Cheok et al, 1996).
- Increased mortality, including by suicide, when anxiety and depression remain untreated in dementia (Fiske, Wetherall & Gatz, 2009).

Suicide in Older People

- Men aged 85+ remain at the highest risk of suicide
- Less warning/explicit cues
- High lethargy due to frailty or intent to die
- Less history of previous attempts
- Greater prevalence of depression in context of physical illness
- Hopelessness
- Less likelihood of contacting mental health services

(Fiske & Arbore, 2001)

Suicide in Older People

- When physical health is severely impaired what we may see is:
  - Isolation and withdrawal
  - Suicidal ideation
  - Intentional self-neglect

Comorbidities

- Older person was admitted to RACF due to declining health (physical, neurological or mental health)
- Slow growers versus sudden attackers (dementia versus CVA)
  - Slow growers usually adapt easier than those who have had sudden change in circumstance
  - The importance of involving the older person in the proess
- Bi-directional impact of poor mental health and declining physical health

What Works

- Cognitive Behavioural Therapy (CBT)
  - Consistent with person-centred care (Kitwood, 1997)
  - Substantial evidence on effectiveness of CBT in dementia
  - CBT strategies can assist to adapting to new environment and routines
- Reminiscence and Life Review
  - Simple reminiscence and reminiscence therapy (Bhar, 2014)
  - Life review and life review therapy

Revisiting Jim and Elaine

- Individual sessions and therapy goals
- Jim – to adapt to new environment and identify enjoyable activities, form friendships and improve relationship with his son
- Elaine – to support her adjustment to new environment, address health anxiety and identify opportunities where she can meaningfully contribute (e.g. laundry and setting up tables in the dining room)
- Jim – completed 10 sessions (pre GDS 25/30; post 12/30)
- Elaine – completed 12 sessions (pre GAI 16/20; post 8/20)

Collaboration to Maximise Client Support Whilst Maintaining Confidentiality

- Other health professionals visit RACFs and may be supporting the same client (OTs, physiotherapists and speech pathologists)
- Working to support client and their goals
- Liaising with staff on-site to support client with any tasks in between consultations
- If and when appropriate to liaise with families

Strategies to Boost Social Connection

- Regular contact with friends and loved ones
  - Encourage calls, letters, cards and engagement with service delivery
- Good support system
  - Involve support people in service delivery and encourage regular socialisation
- Keeping physically active
  - Incorporate into daily activities e.g. walking inside/outside
- Practising self-care strategies
  - Mindfulness, meditation, getting nails/hair done,

Strategies to Boost Social Connection

- Maintaining hobbies and interests
  - Swap do not stop, finding activity that the individual can maintain (physically and financially)
- Enjoying music and art
  - Support if assistance required to set up
- Interacting with pets
  - Can incorporate wildlife (sitting out the back with the birds)

Research Corner

- Emotional and Psychological Wellbeing in Home Care Workforce
- Mixed method (4) studies:
  - Study 1 Organisational Factors of Home Care Qualitative Study
  - Study 2 Prevalence of Mental Illness in Clients Qualitative Study
  - Study 3 Quantitative Study Emotional Contagion Quantitative Study
  - Study 4 Examine the role of worker self-efficacy Quantitative Study

Research Corner

- Emotional contagion: “catching” emotions from clients
  - Catching positive emotions = positive effect and improved mood and wellbeing
  - Catching negative emotions = negative effect and deteriorated mood
- Implications = positive interactions lead to better service delivery; exchange of negative emotions impacted worker’s own wellbeing, job satisfaction and intention to stay
- Screening client mental health to minimise environmental risks

Thank you

Q&A

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