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ENHANCING MENTAL HEALTH IN RESIDENTIAL AGED CARE: A PRACTICE GUIDE FOR CLINICIANS

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Executive summary

The prevalence of mental health conditions in residential aged care homes in Australia is substantially higher than in the community. There are no practice guidelines for how best to support the mental health of older adults living in residential aged care. Most research about psychological treatments for mental health difficulties in older adults has focussed on people living in the community and has typically excluded those with cognitive impairment and physical ailments – two conditions that are typical in aged care residents. This guide offers mental health clinicians an overview of practical approaches for supporting the mental health of aged care residents. It provides insights for adapting and delivering psychological treatments to overcome multiple barriers to care within such settings.

Chapter 1
Introduction

In Australia, like many parts of the world, residential aged care (RAC) services have become increasingly common as people live longer and need supported accommodation. RAC services are provided to individuals who require prolonged skilled nursing care in institutional settings. In Australia, such settings are variously referred to as RAC facilities (RACFs), RAC homes (RACHs), nursing homes, or aged care residences. In the US, these settings are called skilled nursing units, or long-term care facilities. In the UK, they are called aged care homes. In this practice guide, we use the term residential aged care homes or RACHs to refer to these settings.

People prefer to live independently in their own homes or with families.[1] In Australia, older people are provided with an array of support services - rehabilitation services, access to subsidised home care services and use of assistive technologies - to support the decision and preference to live at home.

But many of us may reach a stage in life when we can no longer care for ourselves without more intensive support. In Australia, there are now almost a quarter of a million older adults living permanently in residential aged care homes (RACHs).[2] With longer life spans, the Department of Health and Ageing has projected that between 30 per cent and 50 per cent of older adults will eventually need to enter into such care arrangements, particularly if their needs cannot be met in the community.[3]

This practice guide

This guide provides mental health clinicians with an overview of practical and innovative strategies for supporting the mental health of aged care residents. This guide aims to translate research into practice for implementation in RACHs. To consider the practicalities and challenges of working within a residential aged care environment, using case examples to highlight the common mental health difficulties in this setting and demonstrate how management techniques can be applied.

This guide is intended to be a practical resource, which tells you *how* to do things rather than just *why* they matter. Step-by-step protocols and case illustrations that demonstrate recommended strategies are provided.

Using an evidence-informed approach, which draws from research literature, best-practice guidelines, and clinical expertise will support you to make clinical decisions and develop sound treatment plans.

This guide is intended for mental health clinicians working in residential aged care settings. It has been tailored to consider the clinical realities for working in such settings, highlighting the barriers you may face working in aged care and suggesting potential solutions.

Resources such as links to assessment tools, online training and treatment materials have been included, so that you can use this guide as a reference point to support your professional development and clinical work. Artificial intelligence generated podcasts are also included for each chapter so you can listen to an audio version of the guide.

Chapter 2 provides a beginner's guide to Australia's aged care system, with a particular focus on the residential aged care system in case you are less familiar with the aged care sector compared to mental healthcare approaches.

Chapter 3 reviews common mental health issues experienced by aged care residents. Mental health conditions in such populations are often complicated by comorbid physical disorders and cognitive impairment.[4] As a result, clinicians may be less familiar with the mental health profile of residents compared to their community dwelling clients. Links to commonly used assessment measures developed for people living in residential aged care are provided.

Chapter 4 provides an overview of how clinicians can work with aged care residents living with dementia, and the common non-pharmacological approaches to supporting mental health symptoms in this population. Given that more than 50 per cent of aged care residents live with dementia,[5] you are likely to have clients in RACHs with this diagnosis or with significant cognitive impairment.

Chapter 5 provides an overview of evidence-based psychological treatments for use in RACH settings. In most cases, these treatments were developed for younger adults (aged 18-64). In these chapters, step-by-step instructions of how you can provide these treatments to your clients living in residential aged care are provided.

Chapter 6 provides a guide on how to use telehealth to deliver psychological treatments. Raising solutions to common obstacles of telehealth delivered treatments.

Chapter 7 identifies the barriers to delivering psychological treatments within RACHs and offers suggestions for overcoming them.

Chapter 8 proposes a model of care that is systemic, where the treatment approach involves residents, their families and staff. Such a model is a departure from the individualistic, one-to-one, or 'practitioner to client' approach commonly used in outpatient psychology settings. Case illustrations demonstrate the application of this model in RACHs.

Chapter 9 pulls the information together to show how assessment and treatment can be delivered systemically and in a way that overcomes barriers to care.

Chapter 10 concludes the guide by succinctly summarising the approach to mental healthcare in RACHs and emphasising the need for more training in aged care mental health.

Chapter 2
Australia's aged care system

Australia's aged care system is undergoing transformation. The findings of the recent Royal Commission into Aged Care Quality and Safety were published in 2021[6] and since then, several changes have occurred in the aged care sector. Minimum care minutes have been mandated for residents, RACHs are now rated by a star system, and wages for aged care workers have increased. The Aged Care Act has also undergone revision, with more emphasis placed on strengthening principles of person-centred care and dignity.

Despite these changes, our aged care system remains divided into two main sectors: community aged care (also called in-home care) and residential aged care. The two systems have different policies, access issues, and healthcare practices. Practices in one sector may not always translate to the other.

Community aged care

Older adults prefer to live at home, either in their own homes or with family.[1] Some may choose to move into a retirement community – such as a retirement village or an independent living community (often in high rise apartments). To receive community aged care, individuals need to be assessed by My Aged Care and allocated services based on their level of need. The Australian government spends millions in supporting older adults to remain in the community by subsidising or covering the cost of these services.

Residential aged care

Once older adults are assessed and recommended as no longer able to live independently in the community, they may become eligible for residential aged care services. In RACHs, residents are cared for by professional carers – primarily personal care workers, along with nurses (enrolled and registered), allied health staff (such as physiotherapists), and medical staff, typically visiting general practitioners.

RACHs provide accommodation and assistance with:

- day-to-day tasks, such as cleaning, cooking and laundry
- personal care, such as bathing, dressing and going to the toilet
- access to health practitioner services, clinical care and therapies
- other services, such as social and emotional support, and entertainment.

The following information provides an overview of the residential aged care system in Australia. It is worth noting this information will be updated regularly. For the most current details, visit the following website: https://www.gen-agedcaredata.gov.au/

As of 30 June 2024, 736 providers were delivering residential aged care through 2617 services. Since 2017, the number of providers has decreased, but the number of services has remained stable. However, the total number of residential aged care places has increased, with 223,691 places now available.

More than half (63%) of residential care services across Australia are based in metropolitan areas. Most services are in New South Wales (832) and Victoria (741). Most RACHs are operated by not-for-profit organisations (57%), including religious, charitable and community-based groups, followed by private organisations (35%) and government-run services (8%).

In summary, aged care providers are expanding to include more aged care services. Over time, the size of residential aged care services has changed, with fewer smaller services (those with 60 or fewer operational places) and more larger services (those with 100 or more operational places). On average, these services now accommodate 85 residents.

Between 2017 and 2024, the number of people using permanent residential aged care increased by 6.3 per cent (from 179, 000 to 190, 000). Of those in permanent residential aged care, 66 per cent are women and 34 per cent are men. Most (59%) permanent residents are aged 85 years or older. The median length of stay in permanent residential aged care is 21 months, and the majority (84%) of 'exits' from care are due to death.

Mental health services in residential aged care

Psychological services in RACHs are not typically part of standard care. The primary treatment for mental health issues in these facilities is medication, most commonly antidepressants, antipsychotics and anxiolytics.[7] Medications are more frequently recommended than non-pharmacological approaches, despite studies showing that non-drug treatments can be effective and may carry less risk of harm.[8]

Medicare services

Residents have access to subsidised psychological services through two Medicare schemes: Chronic Disease Management (CDM) plans and the Better Access initiative. CDM plans help the resident's medical practitioner (usually a GP) coordinate healthcare for patients with chronic or terminal medical conditions. Patients under these plans can receive five subsidised allied health services each calendar year. For more information about this plan, visit: https://www.servicesaustralia.gov.au/requirements-for-chronic-disease-health-care-plan?context=20

The Better Access initiative provides Medicare rebates to help people access mental health professionals and care, regardless of where they live. Support is available from eligible GPs, prescribed medical practitioners, psychiatrists, psychologists, accredited mental health social workers and eligible occupational therapists. Medicare benefits are available for a maximum of 10 individual and 10 group allied mental health services each calendar year. Aged care residents can access Better Access services if they are referred by a psychiatrist. For up-to-date information about this initiative, see https://www.health.gov.au/our-work/medicare-benefits-schedule-better-access-initiative-mental-health-support-for-aged-care-residents-during-the-covid-19-pandemic

Public mental health services

The Victorian older adult clinical mental health system includes fourteen Older Adult Clinical Mental Health (OACHM) services, which support individuals aged 65 years and older, as well as First Nations people aged 50 and older. These services offer treatment for those experiencing long-standing mental health challenges or functional illnesses that have developed later in life. They also provide support to older adults living with psychiatric or severe behavioural difficulties associated with organic disorders such as dementia. The services include community-based older adult clinical mental health teams, acute inpatient services, intensive community treatment programs and residential care.

In addition, there are specialist residential care services for older people with a mental illness who are unable to live at home or be supported in mainstream aged care residential services. These services provide accommodation, ongoing assessment, treatment and rehabilitation as a transition to mainstream residential care. For more information, visit: https://www.health.vic.gov.au/mental-health-services/older-adults

Primary health networks

Primary Health Networks (PHNs) are locally based organisations that identify regional needs and commission services accordingly. They aim to enhance service integration, focus on vulnerable populations, and ensure care is efficient and accessible. In 2018, PHNs were tasked with coordinating and commissioning psychological services for RACHs. The Australian government funded 31 PHNs across Australia to make psychological services more accessible to residents than ever before. For more information, visit https://www.health.gov.au/resources/publications/primary-health-networks-phn-mental- health-care-guidance-psychological-treatment-services-for-people-with-mental-illness-in-residential-aged-care-facilities?language=en

Wellbeing clinic for older adults

The Wellbeing Clinic for Older Adults is a national specialist mental health service based at Swinburne University, offering psychological support to older adults in residential aged care and the community. Staffed by postgraduate students studying psychology, counselling, or social work, under expert supervision, the clinic provides evidence-based therapies for depression, anxiety, grief, and adjustment issues related to ageing. Services are free, accessible via telehealth or in-person, and tailored to the unique needs of older adults. The clinic also plays a key role in training future mental health clinicians in applying psychological treatments to older adults ("geropsychology") and contributes to research focused on improving mental health care for Australia's ageing population. For more information, see https://www.swinburne.edu.au/research/centres-groups-clinics/wellbeing-clinic/

In-house mental health services

Some RACHs employ or contract mental health clinicians, such as psychologists, social workers and counsellors, to provide counselling and psychological services to residents. However, in our experience, this arrangement is not typical across the residential aged care sector in Australia. More commonly, RACHs offer all residents access to lifestyle and leisure activities, volunteers (e.g. befrienders or community visitors) and pastoral care staff (e.g. chaplains, spiritual care practitioners, or pastoral care counsellors). Some research has found that such programs (e.g. music, dance, befriending) can be effective for addressing loneliness, depression and anxiety in residents.[9]

Chapter 3
Mental health issues in residential care: Symptoms and assessment

Mental health issues such as depression, anxiety and suicidal ideation are highly prevalent in RACHs. A review of the records of 430,862 aged care residents (aged 65 or older) living in Australia found that 57.8 per cent had at least one mental health disorder,[10] with the most common being depression. Almost 60 per cent of individuals with a mental health disorder who were reviewed in this study also had physical health comorbidities – most commonly, musculoskeletal disorders, incontinence, diabetes and dementia. Having multiple physical health disorders was associated with an increased risk of having a mental health disorder.

In this chapter, we provide an overview of commonly observed mental health conditions among aged care residents, as well as an overview of contributing factors to these issues. We also highlight commonly used assessment tools and potential opportunities for intervention.

Depression

An international review of prevalence studies in RACHs found that the median prevalence rate of Major Depressive Disorder was 10 per cent.[11] In an Australian study, 32 per cent of residents were found to have symptoms of depression, compared with 14 per cent of non-institutionalised older adults.[12] Similarly, a study in the UK indicated that the rate of depressive symptoms among aged care residents was twice as high as that among community-dwelling older adults.[13]

Why are prevalence rates of depressive symptoms so high in RACHs? Such symptoms may be due to a number of factors, including multiple medical conditions, a decline in daily functioning and cognitive impairment – all of which are established risk factors for depression. Depression may result from loneliness. A review of 13 studies involving 5115 residents found that 35-61 per cent of resident's report feeling lonely.[14] Although RACHs provide opportunities for social activities, it is not uncommon for individuals to spend most of their time isolated in their rooms, with limited social interaction with others during mealtimes.

Low mood can be particularly heightened in newly admitted residents, with high rates of depression relating to the transition into residential aged care.[12,15] Many older adults move into residential aged care during a crisis, such as following a fall, an acute hospitalisation or the death of a spouse.[16] Admission to care may be followed by further losses – such as the loss of autonomy, independence, relationships, privacy, meaningful activities, valued routines, roles, and self-identity.[17] These losses can impact negatively on the person's experience of transition and subsequent adjustment to their new circumstances.[18]

Mental healthcare clinicians can play a vital role in helping new residents adjust to their changed circumstances. In our experience, many RACHs do not have formal programs to assist residents in transitioning to these facilities. A novel program called PEARL was evaluated and found that in five sessions, clinicians could help individuals adjust to care.[19] To watch a pre-recorded webinar on this innovative program, visit https://commons.swinburne.edu.au/items/976ba571-61e1-4e6f-b48c-86062844d2b3/1/

Common tools for assessing depression

- There are several measures for assessing depressive symptoms in RACHs. While none of these measures determine if criteria for a disorder are met, they can provide an estimate of the severity of depression. These tools can be used to determine eligibility for a program (e.g. resident must meet a minimum threshold), monitor response to treatment (e.g. tracking symptom severity) and identify indications of risk (e.g. residents endorse items measuring suicidal ideation or behaviour). Additionally, we have also found that some residents appreciate the opportunity to talk about their difficulties in a structured way. Administering these measures can serve as a prompt for structured conversation and help develop rapport with the resident.
- **Cornell Scale for Depression in Dementia (CSDD):**
  This 19-item tool is widely used in residential aged care settings as it can be used with people living with dementia and those without. The tool looks at the person's depressive symptoms over the previous week using comprehensive interviews with the person and someone who has been in regular contact with them. The tool and a guide to scoring can be found at: https://www.dementia.com.au/resource-hub/guide-to-using-the-cornell-scale-for-depression-in-dementia
- **Geriatric Depression Scale (GDS):**
  The GDS is available in 30-item, 15-item, and 8-item versions which are all designed to be used with people with no, or only mild cognitive impairment. A 12-item version (GDS-12R), specifically focused on depression in residential aged care, is suitable for use with people without, as well as with, cognitive impairment. All versions can be completed by the person being screened on their own or administered in an interview format. As these tools use a simple yes/no response format, they do not require training to administer. For more information about the GDS-12, see https://www.intpsychogeriatrics.org/article/S1041-6102(24)00132-7/fulltext
- **The Patient Health Questionnaire-9 (PHQ-9):**
  The PHQ-9 is a widely used screening tool for depression and has been used extensively in residential aged care settings. Research suggests it can be a helpful tool for detecting depression in residents. The tool can be found here: https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf

Suicide

Rates of suicidal ideation are higher in RACHs compared to the community. Up to 33 per cent of aged care residents have been found to experience suicidal ideation,[20] a rate that is up to four times than that found in community-dwelling older adults.

In contrast, rates of suicide attempts and suicide are typically lower in RACHs than in the community.[21] For example, Abrams and colleagues found that the number of suicides in RACHs was 19.74 per 100,000 residents, compared to 98.56 per 100,000 in the general population.[22] Such findings may reflect the protective function of greater levels of supervision and reduced access to means for suicide in residential compared to community settings.

In their systematic review of five studies of suicide methods in residential aged care settings, Murphy and colleagues[23] found that the most common methods were hanging and jumping from a bedroom window or fire escape. Other methods were drug toxicity, drowning and cutting. The reviewers identified only single instances of suicide by firearm or plastic bag asphyxia.

The most frequently reported risk factors for suicide in RACHs include depression, personal loss, decline in physical health and more recent admission to the facility.[23] Across three studies, 52 per cent of residents who died by suicide had lived in the RACH for less than 12 months.[23] These findings suggest that aged care residents are at the highest risk during the first year of moving into a RACH home.

Suicide risk assessment

Risk assessment protocols can vary across organisations, so it's important to be familiar with the policies in your organisation and RACH. Below is an approach that is used in the Swinburne Wellbeing Clinic, that you may find useful to employ or adapt.

In the event that a resident provides information that prompts you to wonder about their risk for suicide, conduct a risk assessment. There are several established risk assessment protocols in the field. In most of these protocols, you ask questions to determine the level of risk. Common questions include:

- Are you thinking of killing yourself/ending your life? (to identify suicide ideation)
- Do you have any desire to kill yourself? (to identify suicide desire),
- Have you been thinking of acting on this desire, or how close have you come to acting on these thoughts? (to identify suicide intent), and
- Have you thought about how you would kill yourself, and do you have the means to act on this plan? (to identify suicide plans and means).

At the Swinburne Wellbeing Clinic for Older Adults, risk is categorised as follows.

Category	Definition
No suicide risk	No endorsement on suicide ideation, desire, intent, means or plan
Low suicide risk	Endorsement on suicide ideation or suicide desire only, but not suicide intent, means or plan
High suicide risk	Endorsement of suicide intent, even if not suicide means or plan

The following steps are to be undertaken for each category.

Category	Steps
No suicide risk	No action required.
Low suicide risk	Acknowledge that the client is dealing with very difficult feelings and/ or particularly stressful circumstances in their life. This can be containing and immediately helpful. *Protective factors:* Ask the client what has kept them from harming themselves to date. Most people are very ambivalent about ending their life and would prefer to be able to resolve the difficulties that they face. Focusing on what has kept them going can help to keep them in touch with their desire to live. Consult with clinical supervisor within 24 hours to determine the next steps
High suicide risk	As above for Low suicide risk, plus the following: • Co-construct a safety plan. • Advise the client that you feel they need specialised support and assessment and that this needs to be arranged. • Consult with your clinical supervisor immediately to determine the next steps. You may also need to contact the client's emergency contact directly following the assessment.

If you believe that the resident or someone else is at risk of immediate harm, please contact emergency services accessible to the client. You will need to speak with the clinical care manager or residential care manager in order to help keep the client safe.

You do not need to feel solely responsible for managing suicide risk. Your supervisor or line manager is a primary source of consultation and support - please seek their input. Do not consider your lack of reaching out as a sign of your independence or resilience. It is good practice within suicide prevention teams to regard suicide prevention as a team effort.

Carefully document the steps you took to make a suicide assessment (what questions you asked), the answers that you received from your client that informed your risk assessment (what the client said that led you to decide the risk level), whom you consulted, and what action you took to reduce the risk of suicide. While you are not expected to be 100 per cent confident in your determination of risk, you are expected to be able to clearly document how you arrived at your determination - that is, the evidence you considered in reaching your determination

What can clinicians do to prevent suicide in RACHs?

There is limited research on suicide prevention intervention in RACHs. In their systematic review of suicide prevention interventions, Chauliac and colleagues[24] found only six studies that investigated programs for reducing suicide in residential aged care settings. Of these, one study used life review, another used behavioural activation, and the remaining four focused on improving the skills of RACH staff to detect and care for suicidal residents. The evidence for these interventions in RACHs was poor.

The following suggestions are offered for your consideration:

- Regularly screen for depression and follow up on the results. These steps are viewed as critical for preventing suicide. Helping residents come to terms with losses and transitions, together with reducing depression are obvious targets for intervention.
- Address issues related to moving into residential aged care. Suicide risk is highest within the first 12 months of living in residential care. For residents who have had recent losses, particularly the death of a spouse, a grief counselling approach is recommended.
- Support residents in a number of ways: reflect on reasons for entering residential aged care, help the resident feel supported and less isolated, develop strategies to help residents feel more autonomous, and acknowledge the resident's identity and losses. For a refresher on suicide prevention for older adults, see: www.anglicare.org.au/suicideprevention
- Social isolation and feelings of loneliness are common in residential aged care, particularly for new residents, and can increase suicide risk. Clinicians can work with lifestyle coordinators to expand the resident's social network. Tools such as the Pleasant Events Schedule-Nursing Home[25] can be used to identify resident interests and groups of residents who have similar interests. Clinicians could also consider group work, allowing residents to share emotions with peers of similar age, which can help validate their feelings.
- Problem solving therapy has been used to reduce suicidal ideation in community dwelling older adults with executive dysfunction,[26] suggesting that this therapy has potential for use in residential aged care given most residents have cognitive impairment. The hallmarks of problem solving therapy are identify a relatively "easy to solve" problem, encourage brainstorming solutions, and help the resident decide on a solution based on pros and cons of each solution. See chapter 5 for more information about this approach.
- Mental health clinicians can also play an active role in staff education regarding preventing suicide. Changes in mood and behaviour, such as increased isolation, refusal of medication, or neglect of self-care are important observable signs of deterioration in mental state that can be shared with staff. It is essential that RACH staff learn how to respond to statements from residents expressing a desire not to live. Clinicians can use teaching techniques such as modelling or role plays to help staff become more comfortable with appropriate responses. Clinicians can also support staff in helping suicidal residents.

Resources for assessing and managing suicide risk include:

- The Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS), supports suicide risk screening through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, determine the severity and immediacy of that risk, and gauge the level of support that the person needs. https://cssrs.columbia.edu/
- When risk is identified, it is important to create a safety plan and to work systemically with staff, other specialists and family to provide support for the resident.[27] The following paper by Conti and colleagues[28] provides a clear overview of indicators of risk and questions that can be asked to assess the level of risk. This article is free to access. https://pmc.ncbi.nlm.nih.gov/articles/PMC6858938/
- The Beyond Now web app is a user-friendly suicide safety planning tool. This Australian developed resource contains local helplines, and is to be used via the webpage or an app. This feature does restrict it to those who carry a laptop, tablet or smartphone. You would need to have RACH staff print the hardcopy. The tool may also be a resource that steps the clinician through the safety planning process. https://www.lifeline.org.au/get-help/beyond-now/create-your-beyond-now-suicide-safety-plan-online/
- Another example of a safety plan is found here https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf
- To provide training to others on suicide prevention, you may be interested in reviewing this detailed manual. https://library.samhsa.gov/sites/default/files/trainersmanual.pdf

Anxiety

As with depression and suicidal ideation, rates of anxiety disorders and symptoms are higher in residential aged care settings than in the community. For example, in their systematic review, Creighton and colleagues found that anxiety disorders in residential aged care settings ranged from 3.2-20 per cent, compared with estimates of 1.4-17 percent in the community.[29] This review also examined the number of older people living RACHs who experienced anxiety symptoms that warranted intervention, but who did not meet strict criteria for a psychiatric diagnosis. The rate of such anxiety symptoms of residents ranged from 6.5-58.4 per cent, compared to 4.7-24.4 per cent in the community.

The most commonly reported anxiety disorders in aged care residents are generalised anxiety disorder (GAD) and specific phobias.[29,30] Anxiety conditions such as agoraphobia, social anxiety disorder and panic disorder appear to be relatively uncommon among residents.[30] Compared with depression, anxiety in RACH populations has not received much attention. Anxiety can also be difficult to distinguish from agitation, particularly in those with poor cognitive functioning. Hence, it is likely that anxiety is overlooked and under-reported by facility staff and medical providers.

Common tools for assessing anxiety

- Rating anxiety in dementia scale (RAID). The RAID is an 18-item clinical rating scale specifically developed to assess anxiety symptoms over the last two weeks in people with dementia.[31] The measure is completed by the clinician using information from interviews conducted with the patient and an informant, and consists of four subscales: worry, apprehension and vigilance, motor tension, and autonomic hypersensitivity. Scores range from 0-54, with each item rated on a scale of 0 (absent) to 3 (severe). Higher scores indicate higher levels of anxiety. https://www.dementiaresearch.org.au/wp-content/uploads/2016/06/RAID.pdf
- Geriatric anxiety inventory (GAI). The GAI is a 20-item self-report screening tool which uses language commonly used by older adults to describe anxiety (e.g. “nerves”, “butterflies in my stomach”) and assesses the presence of generalised anxiety symptoms over the past week.[32] Each item uses a dichotomous agree/disagree format to facilitate its use with individuals with mild cognitive impairment and lower levels of education. Scores range from 0-20, with higher scores indicating higher levels of anxiety.[32] Short forms of the scale have also been developed. https://gai.net.au/
- Generalised anxiety disorder scale (GAD-7). The GAD-733 is a 7-item self-report measure of the presence and severity of GAD in clinical practice. A score of 10 or greater on the GAD-7 represents a reasonable cut point for identifying cases of GAD, although some authors suggest using an adjusted cut off of 5. Cut points of 5, 10, and 15 are interpreted as representing mild, moderate, and severe levels of anxiety. https://www.ndss.com.au/wp-content/uploads/Generalized-Anxiety-Disorder-Seven.pdf
- Patient Health Questionnaire-4 (PHQ-4). The PHQ-4[34] is a 4-item self-report instrument that combines 2 items of the PHQ-9 and 2 items of the GAD-7. Items are answered on a 4-point Likert scale ranging from 0 (“not at all”) to 3 (“almost every day”). It is possible to estimate a general scale for assessing distress (PHQ-4) by combining both subscales, although subscale scores (PHQ-2 and GAD-2) can also be computed. The total scale (PHQ-4) ranges from 0 to 6, with a score of ≥6 signifying distress, while subscales with cut-off points of ≥3 indicate probable cases of depression or anxiety. https://www.phqscreeners.com/

Personality disorders

The prevalence of personality disorders (PDs) in RACHs is unclear. In a recent systematic review, Penders and colleagues found no published study between 2014 and 2019 that exclusively surveyed the prevalence of PDs in residential aged care settings.[35] They included one study that examined the prevalence of PDs in a mixed sample of 83 older adults living in RACHs or who attended senior citizen clubs.[36] In this mixed sample of older adults, 58 per cent were diagnosed with a personality disorder (PD), most commonly avoidant PD (20.5%), obsessive-compulsive PD (12%) and paranoid PD (12.0%). The extent to which such prevalence rates apply to residential aged care settings remains to be explored.

Although the prevalence of PDs among aged care residents has received limited research attention, the adverse effects of this condition on the wellbeing of the resident, other residents and RACH staff are recognised as considerable. For example, residents with a diagnosis of PD (such as Borderline PD) may repeatedly complain about nursing care, demonstrate hostility, complain about the lack of care and attention from family members, refuse to comply with treatment, and experience frequent mood changes and emotional outbursts.[37] Staff may on occasion begin to avoid such residents because of their experience of abuse and endless demands.

Schema therapy[38] and dialectical behaviour therapy[39] have been considered promising for community dwelling older adults, but the trials of such approaches for residential aged care populations are yet to be conducted. Clinicians might focus on reducing dysregulation of emotion of aged care residents with PD as well as assist RAC staff to cope with such residents. For example, clinicians can use behaviour management skills, self-soothing techniques and de-escalation strategies to assist aged care residents to regulate emotions. Clinicians can also support staff through education and debriefing, in order to help them to consider the tacit functions of residents' behaviour. Clinicians can also assist in developing a plan for how staff can respond to residents' challenging behaviours.

Webinars on assessing and managing personality disorders in older adults

- **Personality disorders in older adults**
  https://commons.swinburne.edu.au/items/d42374ae-37b0-45ec-8123-67761c1ea777/1/

Trauma

Trauma results from an event(s) or set of circumstances that are experienced or perceived as life-threatening or pose a significant threat to a person's physical or psychological wellbeing. Examples of potentially traumatic events can include acts of violence, natural disasters, interpersonal violence, chronic social adversity or discrimination, accidents, or medical incidents. It is estimated that more than 70 per cent of older adults may have had some experience of trauma.[40]

Late-life can be marked by a series of losses, including retirement, bereavement, decreased social support, declining health and reduced autonomy. These experiences may be inherently traumatic, particularly when they involve significant life transitions where the individual has little control. For example, an individual may be suddenly admitted into residential aged care with limited personal choice due to medical circumstances. Additionally, certain aspects of the residential aged care environment (e.g. loss of personal possessions or power imbalances between residents and staff, and the broader aged care system) may trigger the re-experiencing of past trauma for some older adults, particularly those with histories of childhood institutional care, incarceration, or involuntary hospitalisation. Moreover, older adults' capacity to engage in previously implemented 'avoidance' activities, or to implement their usual coping strategies while residing in residential aged care, may be reduced (Rutherford et al., 2021).

Post-traumatic stress disorder (PTSD) is a mental health condition that can develop after experiencing or witnessing a traumatic event. It is characterised by persistent and distressing symptoms that significantly impact an individual's daily life. The prevalence of PTSD in older adults ranges between 2-4 per cent.[41] Symptoms of psychological trauma can closely mirror the behavioural and psychological symptoms of dementia, making differentiating between the two particularly challenging in older adults. For example, trauma-related presentations such as irritability, anger, persistent negative emotional states, sleep disturbances, wandering, and screaming can be mistaken for *'responsive'* behaviours associated with dementia (Van Dongen et al., 2022).

Some individuals recover well in the short-term, while others may experience difficulties immediately or much later in life. For residents, trauma-related symptoms may re-emerge and present in various ways, including distrust of other residents' and facility staff, social withdrawal, reactive or "explosive" behaviour, symptoms of anxiety or depression, co-morbid insomnia and attention difficulties, heightened sociability or "people-pleasing" behaviours towards staff, and the use of longstanding coping behaviours that may seem unusual (e.g. wandering).

Trauma informed care

Trauma-informed care involves creating a safe and supportive environment that considers how trauma can influence a person's emotions, thoughts and behaviours, while acknowledging potential triggers, and offering individuals choice and control. It is grounded in empowerment and focuses on individuals' needs, strengths, resilience and beneficial coping strategies, rather than their challenges.

For clinicians, it is important to acknowledge that some older adults may not readily express or even identify trauma-related experiences. This may be due to personal reasons, cultural norms around stoicism, historical stigma surrounding mental health, and limited opportunities to discuss emotional distress earlier in life. Nevertheless, in implementing a trauma-informed approach, it is not the aim to 'investigate' or elicit disclosures of trauma experiences from clients, but rather to create a safe environment where any information shared should always be offered voluntarily and with the client's informed consent.

As such, where it is suspected that an older adult is experiencing mental health challenges due to historical, recent or ongoing trauma experiences, clinicians may choose to approach initial interactions by asking questions centred on the therapeutic work, rather than the trauma itself. For example, '*Is there anything about your past that might affect our work together that you would like me to know?'* or *'Do you have any important preferences or requests that would ensure you feel safe while we work together?'.*

Trauma-informed care with older adults should focus on three core objectives: first, restoring the client's sense of agency and power; second, creating a sense of safety; and third, building the client's self-worth. These objectives should be pursued while maintaining an overarching commitment to maximising client choice, control, and autonomy in every interaction.

Resources for trauma informed care

- **Blue Knot Foundation:**
  Provides resources, training, and clinical guidelines for health professionals working with adults who have experienced complex trauma. https://blueknot.org.au/
- **Phoenix Australia:**
  Australia's national centre of excellence in post-traumatic mental health. Phoenix Australia offers evidence-based resources, training programs, clinical tools, and policy guidance for practitioners and service providers.
  https://www.phoenixaustralia.org/
- **TraumaConnect:**
  A national online platform offering counselling, resources, webinars, and peer connection for trauma-impacted clients and clinicians supporting them.
  https://traumaconnect.org.au/
- **Webinar on trauma informed care in aged care:**
  https://commons.swinburne.edu.au/items/4abb5719-028b-420d-9276-aaea39d1ae55/1/
- **Substance abuse and mental health services administration (2014):**
  SAMSHA's concept of trauma and guidance for a trauma informed approach.
  https://www.traumainformedcare.chcs.org/resource/samhsas-national-center-for-trauma-informed-care/

Treatment planning

Residents are likely to present with more than one disorder, symptom or concern. The Initial Assessment and Referral Decision Support Tool (IAR-DST) was developed by the Australian Department of Health to help clinicians assess mental health needs across eight domains and recommend suitable care levels. https://iar-dst.online/#/

Chapter 4
Working with residents living with dementia

Worldwide, approximately 50 million people live with dementia, and by 2050, this number is projected to increase to 152 million.[42] There are almost 10 million new cases of dementia worldwide each year, or one new case every three seconds.[42] Dementia has significant personal, social, and economic impacts, affecting not only individuals but also families, caregivers, and communities. Early diagnosis, supportive care and a person-centred approach are vital in supporting dementia and maintaining dignity and quality of life.

The rates of dementia in residential aged care settings are high. A meta-analysis of 19 studies covering 14 countries, found that the prevalence of dementia in such settings was 53 per cent, almost five times higher than in the general population aged 65 or older.[43] Of studies reviewed, the prevalence of dementia in these settings was highest in Norway (84%) and lowest in Mexico (11%). The prevalence rates of dementia in RACHs in the US and UK were reported as 49 per cent and 70 per cent respectively.[43] In an updated review, a worldwide average of 57 per cent of residents were living with dementia.[5] In Australia, 54 per cent of aged care residents are diagnosed with dementia.[44]

What is dementia?

Dementia is a collective term used to describe a range of symptoms associated with the progressive decline in cognitive function severe enough to interfere with daily life and independence. It is not a single disease, but a syndrome caused by various underlying brain disorders. The most common form of dementia is Alzheimer's disease, accounting for approximately 60-70 per cent of cases.[45] Other types include vascular dementia, frontotemporal dementia, and dementia with Lewy bodies.

The hallmark symptoms of dementia involve impairments in memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgment. Emotional regulation, social behaviour, and motivation can also be affected. While memory loss is a prominent early sign, dementia, depending on its cause, often affects multiple cognitive domains, leading to complex challenges in communication, reasoning and functioning.

Dementia typically develops gradually and worsens over time. Early-stage dementia may be subtle, with mild forgetfulness and difficulties performing familiar tasks. As the condition progresses, individuals may become confused, disoriented, and unable to recognise familiar people or places. In advanced stages, individuals may lose the ability to care for themselves and require full-time support.

The causes of dementia are diverse, involving neurodegenerative diseases, vascular conditions, traumatic brain injury, infections, and other factors. Risk increases with age, but dementia is not a normal part of ageing. Genetic predisposition, lifestyle factors such as diet and exercise, cardiovascular health, and educational attainment also influence risk.

Currently, there is no cure for most types of dementia, although treatments can temporarily alleviate symptoms and improve quality of life. Non-pharmacological interventions, such as cognitive stimulation, behavioural therapies, and environmental modifications, play a crucial role alongside medications.

Assessment and diagnosis of dementia

Dementia is diagnosed and assessed through a comprehensive process that combines clinical history, cognitive testing, physical and neurological examination, and laboratory investigations. Diagnosis begins with a thorough evaluation of symptoms, including changes in memory, language, problem-solving, and daily functioning, often reported by the individual or close family members. Clinicians also assess behavioural changes, emotional wellbeing, and the progression of symptoms over time.

Standardised cognitive screening tools such as the Mini-Mental State Examination (MMSE), Montreal Cognitive Assessment (MoCA), or Addenbrooke's Cognitive Examination (ACE-III) are commonly used to quantify cognitive impairments. A physical and neurological examination is performed to rule out other causes such as stroke, Parkinson's disease, or delirium. Blood tests help identify reversible conditions like vitamin deficiencies or thyroid dysfunction. Neuroimaging is used to detect brain changes, such as atrophy or vascular damage, that support a dementia diagnosis. In some cases, more specialised assessments, including neuropsychological testing or scans may be required. Diagnosis also considers functional impact and excludes other psychiatric or medical conditions. A multidisciplinary approach, involving geriatricians, neurologists, psychologists, and other specialists, ensures a more accurate diagnosis and guides personalised treatment planning and support for the individual and their family.

Mrs. Iris W., an 84-year-old woman, has been a resident in a residential aged care home for the past 18 months. She has a diagnosis of dementia due to Alzheimer's Disease and a history of generalised anxiety disorder, which predates her dementia. Iris is widowed with two adult children, one of whom visits monthly. Before entering care, she lived alone with support from a home care package. Over the past two months, staff have observed a marked increase in Iris's anxious behaviours. She frequently asks repetitive questions about the whereabouts of her deceased husband and becomes visibly distressed when redirected. Iris is angry that her family has forgotten her and insists that her children have not visited her in months. She has also started refusing to attend group activities or the dining room and expresses fear that "something bad will happen." Her sleep has become disrupted, and she often paces the hallways at night. Care staff report that her anxiety appears to worsen in the late afternoon. A comprehensive assessment was conducted by the facility's visiting psychologist in collaboration with nursing staff. The assessment included a review of Iris's medical history, behavioural observations, and consultation with her GP. The Rating Anxiety in Dementia Scale and the Cornell Scale for Depression in Dementia were used, revealing clinically significant anxiety symptoms (scored 13 on the Rating Anxiety In Dementia) with mild co-occurring depression (scored 8 on the Cornell Scale for Depression in Dementia). Cognitive assessment confirmed moderate cognitive decline with impairments in short-term memory, orientation, and executive function.

Behavioural and psychological symptoms on dementia

There have been several terms over time to describe behaviours associated with living with dementia. One of the most commonly used is "behavioural and psychological symptoms of dementia" or BPSD. There is debate over the suitability of this clinical term risking ignoring the needs of the person.[46] BPSD refer to a broad range of non-cognitive disturbances that affect up to 90 per cent of individuals with dementia over the course of their illness. These symptoms include agitation, aggression, anxiety, depression, wandering, hallucinations, delusions, sleep disturbances, apathy, and socially inappropriate behaviour. BPSD significantly impact the quality of life for both individuals with dementia and their families and often precipitate earlier admission into residential aged care. While medications such as antipsychotics are sometimes used, they carry significant risks, particularly in older adults. As a result, non-pharmacological approaches are recommended as first-line interventions. This case highlights the complex interplay between dementia and anxiety and underscores the importance of appreciating the triggers and potential reasons for anxiety.

Working with people with dementia

Is it worth doing therapy if a person has dementia? This question comes up a lot. Traditionally, mental health clinicians are trained to work with individuals who are cognitively intact. The stereotype of therapy involves two people working together to develop insight about a problem and then to address the problem in a systematic and collaborative manner. Consider the following principles when working with people with dementia.

Get to know the person behind the diagnosis

Know the person behind the illness. In the literature, knowledge about a patient is referred to as "Person Knowledge". This term refers to knowing about someone as a unique individual, as distinguished from knowledge about their illness.[47] Such knowledge is a pre-requisite to person-centred care, as it allows clinician to better understand the perspective of the resident, and to individualise care. In fact, such knowledge is a practical cornerstone of relationship building and key to success in psychosocial interventions and helps clinicians understand and respond to responsive behaviours or engage residents in meaningful activities.

One of the most instructive books on this topic is "And still the music plays"[48] which details different therapeutic opportunities for people with severe dementia. In one chapter, titled "Rock man" the author described a novel strategy that involved organising the environment of the person with dementia to help regulate mood and reduce disruptive behaviours. Clinicians arranged polished stones at the entry of the client's home, which prevented the client from rummaging through the garden for such stones.

Several strategies allow you to develop person knowledge.

- Interview the resident. Talk to the resident about their interests, history, experiences and relationships. Residents with short-term memory deficits can discuss with lucidity and clarity details from past experiences. Ask questions such as "Where did you grow up" and "What was school like for you?". If the resident has mementos or pictures in their room, ask them about these. There is no need to overcomplicate this process. The aim is to get to know the residents. If you would like a more structured approach, see the PELI questionnaire, which comprises 72 question you could ask the resident: https://www.preferencebasedliving.com/for-practitioners/practitioner/assessment/peli-questionnaires/peli-nursing-home-full-version-2-0/
- Interview a family member, friend and/or care staff member. Talk to the residents' carers – both those working in the aged care home, as well as family and friends. You could ask the same questions. Family members may have a historical record of the resident – e.g. an autobiography or life book. Staff may have observations to share – for example that the residents enjoy certain activities or are most comfortable with specific people. You can extend the interview to enquire about the reasons for agitation of responsive behaviours. For example, ask: "What do you think is making <the resident> so anxious at night?" See if you can join a care staff meeting during handover, so you can learn about the residents' health/functioning issues over the past few hours.
- Review paperwork and records kept at the facility about the resident. In our experience, relying on notes is complicated for two reasons. First, notes may not comprise up-to-date information or contain details about the person. Second, access to such records varies between RACHs. Some RACHs may not be willing to share records with you. However, in many homes, you will be granted access to care plans, hospital discharge notes and social histories, depending on the consent arrangements you have with the resident and homes. Again, check if the resident has a life book or digital story, as in our experience, these are invaluable sources of information about the person. Lifestyle staff are also a good resource for information regarding the resident, their background and how best to engage them in therapy.

Dementia is not a description of a person's capacity

It is important to note, that the diagnosis of dementia itself does not convey complete information about the person's capacity to develop insight and work collaboratively with the clinician. In the earlier stages of dementia, it is often the awareness of their cognitive decline that causes distress. Clinicians need to evaluate their own implicit biases attached to the label of dementia. In our own research, we have found that the diagnosis of dementia does not preclude individuals from the potential benefits of psychological approaches to care.

However, as the cognitive deterioration continues, it is likely that an individual with dementia will develop difficulties with memory and orientation. They may have difficulty remembering previous sessions, homework assignments or the clinician. Here, you need to use a variety of orientation and mnemonic techniques to help residents follow, recognise and recall information. Examples of these are as follows:

- Have an exercise book that the resident can keep. In this book, write down the important points from each session. This list forms a reminder for the resident about what was covered in each session.
- Make a poster that the resident can stick to the wall to list out the steps or techniques that you would suggest the resident follow. Use pictures and simple language.
- Involve others so that they can remind the resident and potentially assist the resident to complete exercises between sessions. For example, if you draft an activity schedule for the resident, it may be useful to invite a staff member or family member to join the session, so that they can see what activities the resident is to engage with over the next few days.
- Always wear a name tag with your name clearly written in large font and re-introduce yourself to the resident, particularly if the resident has significant short-term memory difficulties. You may say something such as "I'm Claire, and I've been visiting you weekly over the last month. We have been working together to help you feel better". You may also like to wear similar clothes, or the same perfume, so that you can help the resident recall you using sight and smell prompts.
- Use simplified language and content. When speaking to people with cognitive difficulties, it is important to ensure that your language is simple. Avoid jargon and try to convert questions into instructions. For example, instead of asking "How was your day", try "Tell me about your day". Avoid pronouns and open-ended questions. For more information about how to simplify content, please see: https://www.youtube.com/user/UQDementiaCare
- Use nonverbal modalities to supplement your work. Music, the arts, videos and animals are great resources to help you engage the person and to help regulate mood. There is a lot of research suggesting that music therapy is highly effective for people with memory issues. Similarly, engaging people in art work – either producing art, or seeing art could be very soothing for many residents with dementia. In addition, emerging research is suggesting that animal assisted therapy can be highly effective. Sensory work such as gardening can also be very therapeutic. Be creative in putting together a treatment plan that does not rely solely on language skills.

Nonpharmacological approaches to dementia

There are several non-pharmacological approaches that can help a person with dementia feel less distressed.

Person-centred care

At the heart of non-pharmacological management is person-centred care, which focuses on understanding the individual's unique history, preferences, and needs. Behaviour is seen as a form of communication. Identifying unmet needs (e.g. pain, boredom, loneliness) and tailoring care to address these can reduce distress and improve engagement. For instance, knowing a resident's lifelong habits may help structure routines that feel familiar and soothing. Clinicians can support staff in conducting life history assessments, identifying behavioural triggers, and interpreting residents' actions through a psychological lens. Clinicians can also help staff to translate biographical information into calming routines and emotional validation.

Mrs D, an 85-year-old with Alzheimer's, became agitated each morning. Staff discovered she had worked as a teacher and was used to a structured early routine. By adjusting her schedule to include a quiet cup of tea, soft music, and reviewing the newspaper at 7am, her agitation reduced. Personalising care to reflect her identity brought comfort and reduced distress.

Environmental modifications

Adjusting the physical and social environment can significantly reduce triggers of distress. Examples include reducing noise, improving lighting, ensuring clear signage and creating homelike and safe spaces. Secure outdoor areas can support safe wandering and reduce agitation. Structuring environments to avoid crowding and confusion during transitions (e.g. mealtimes) can also lower behavioural incidents. Clinicians can observe and assess behavioural patterns linked to environmental stressors and recommend dementia-friendly design adjustments, such as signage, lighting and layout to promote orientation and reduce distress.

Mr T, a 79-year-old with vascular dementia, frequently paced and became confused in the hallway. Staff installed clear signs and added murals of nature scenes at corridor ends. They also ensured soft lighting and removed unnecessary clutter. These changes helped orient Mr. T and significantly reduced his restlessness and anxiety.

Meaningful activities

Meaningful activities that align with a person's interests and cognitive abilities help reduce boredom and improve mood. These include art and music therapy, gardening, reminiscence therapy, pet therapy and exercise programs. Sensory-based interventions such as aromatherapy, massage, and multi-sensory rooms (Snoezelen) may be particularly helpful for individuals with advanced dementia. Clinicians may collaborate with lifestyle staff to identify meaningful activities, and to tailor interventions (e.g. art, music, reminiscence) to individual histories and therapeutic goals.

Mrs K, an 82-year-old with moderate dementia, became withdrawn and irritable. Knowing she loved gardening; staff introduced a weekly garden club. She began engaging more, showing pride in planting flowers. Her mood lifted, and she showed fewer signs of irritability. A simple, meaningful activity restored a sense of purpose and enjoyment.

Communication techniques

Staff and carers can be trained in effective communication strategies, such as using simple language, maintaining eye contact, validating emotions and avoiding confrontation. Approaches like Validation Therapy encourage acknowledging the person's feelings and perceptions rather than challenging their reality, which can reduce agitation and defensiveness. Clinicians can train care staff in evidence-based communication strategies such as validation, active listening and de-escalation. Clinicians can also model such behaviours to staff, and provide feedback, and reflective supervision to enhance staff skills in reducing confrontation.

Mr S often yelled during care tasks. Staff were trained in using calm tones, eye contact, and validating phrases like "I know this feels uncomfortable." By slowing down and explaining steps clearly, they reduced Mr. S's fear and resistance. Improved communication led to more peaceful care routines and reduced behavioural outbursts.

Behavioural interventions

Behavioural interventions involve identifying triggers and consequences of specific behaviours (the ABC approach: Antecedent, Behaviour, Consequence). Care strategies can then be designed to prevent or replace responsive behaviours. Cognitive stimulation therapy (CST), while more commonly used to enhance cognition, has also shown positive effects on mood and social interaction. Clinicians can conduct behavioural assessments (e.g. ABC analysis), develop and monitor behaviour support plans, and consult with staff and families on interventions that address unmet needs and reinforce positive behaviours. Trying to uncover the underlying reason for the behaviour or "what is the resident trying to tell me", is central to this approach.

Mrs A repeatedly called out and appeared distressed in the late afternoon. Staff used the ABC approach and realised this occurred after noisy mealtimes. They adjusted her dining experience to a quieter table and scheduled calming music and hand massages afterward. Her distress subsided, and she appeared more settled in the evenings.

Social connection and structured routines

Providing opportunities for social interaction and establishing predictable routines can foster a sense of security and purpose. Group activities, peer support, and family involvement all contribute to emotional wellbeing. Clinicians can identify psychological needs such as belonging and identity and assist in structuring daily routines that offer opportunities for connecting with others and engaging in activities that give purpose.

Mr L, an 88-year-old with dementia, showed signs of depression and irritability. Staff introduced a daily routine including group morning tea, chair yoga and a storytelling circle. With predictable structure and meaningful social contact, he became more engaged, smiled often, and showed fewer signs of agitation and withdrawal.

Training and support for care staff

Educating care staff in understanding dementia, managing BPSD, and practicing self-care is crucial. Supporting caregivers reduces stress, improves the care environment, and ultimately benefits the person with dementia. Clinicians can provide psychoeducation on dementia and BPSD to care staff, offer practical care strategies, and run workshops to help staff manage stress, prevent burnout, and respond empathetically to challenging behaviours.

A residential facility noted high levels of BPSD and staff burnout. They implemented dementia-specific training focusing on validation, de-escalation techniques and self-care. Over time, staff confidence improved, resident behaviour incidents decreased, and the atmosphere in the facility became more relaxed and supportive for both residents and caregivers.

Resources for dementia related support and training

- **Dementia Australia**
  https://www.dementia.org.au/
- **Dementia Support Australia**
  https://www.dementia.com.au/
- **Dementia Training Australia**
  https://dta.com.au/
- **See webinar on responding to individuals with dementia**
  https://commons.swinburne.edu.au/items/913dc13d-af78-4354-907a-1c2bf10277d8/1/

Chapter 5
Evidence based psychological interventions in long-term care facilities

There are several psychological interventions that are promising for improving depression, anxiety and emotional wellbeing of aged care residents. The research base for the effectiveness of interventions in such settings is still developing; there are fewer high quality clinical trials of such interventions for older adults living in RACHs than for those living in the community.

Wells and colleagues[9] reviewed the research evidence for more than 41 psychosocial interventions for late life anxiety and depression in community and residential aged care settings. They found a range of psychosocial (psychological and social) interventions to be supported by at least "two good studies" in RACHs. These included animal-assisted-therapy, music and singing, reminiscence therapy and cognitive behaviour strategies. Further, there have been multiple additional strategies identified to reduce loneliness in aged care residents; these include reminiscence therapy and lifestyle programs such as gardening, recreational activities and volunteering.[49,50]

Cognitive behavioural therapy and reminiscence therapy are reviewed in detail below. In chapter 6, the use of telehealth in delivering these interventions is considered.

Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) is one of the most researched models of psychological treatment across diverse populations, including older adults living in RACHs.[51] In a systematic review of 18 studies of CBT for aged care residents, Chan and colleagues found that CBT was acceptable to aged care residents, judged positively by staff and effective in reducing depressive and anxiety symptoms.[51]

CBT involves a range of strategies such as:

- behavioural activation
- cognitive restructuring
- structured problem solving
- exposure interventions
- distress tolerance skills training.

For an overview of such strategies, watch the following webinars:

- **Cognitive behavioural therapy for older adults**
  https://commons.swinburne.edu.au/items/a126e976-639a-4773-8c80-500aa4343acb/1/
- **Adapting cognitive behavioural therapy for residential aged care**
  https://commons.swinburne.edu.au/items/cbd9c916-4687-418a-a8de-ba45fdf39fbe/1/

Behavioural activation

Behavioural activation involves the scheduling of activities that help the individual feel pleasure, achievement and purpose. Behavioural activation is one of the most research supported interventions for aged care residents. Examples of such programs are BE-ACTIV (Behavioural activities intervention) and PMAL (Positive Mood and Active Life Program). The BE-ACTIV program was developed by Meeks and colleagues. This program involved a 10-week individually tailored activities-based intervention for depression that was implemented collaboratively with residential care staff. The program was found to assist recovery in depressed residents.[52] Another similar program called the "Positive Mood and Active Life Program (PMAL), is a 12-week intervention based on behavioural activation principles. The program was found to improve depressive symptoms and quality of life of aged care residents.[53]

There are a wide variety of activities that can help residents feel less depressed or anxious. These include community befriending services (linking community visitors to aged care residents), arranging for intergenerational activities (e.g. arranging for school aged children to work on joint projects with older aged care residents) as well as lifestyle activities and excursions (e.g. social bingo activities, visiting museums, bus trips).

While many RACHs have busy social activity calendars, such activities are most impactful on resident wellbeing when they are *feasible and tailored* for the resident. For example, some residents may not be able to participate in large groups due to difficulties in hearing or due to feeling nervous in crowds. For these residents, smaller, more intimate groups may be better tolerated. Similarly, some residents may enjoy discussion groups focussed on current news and politics, while others may prefer activities related to nature such as gardening or practical outcomes such as woodwork. We recommend that clinicians and other mental health practitioners learn about the clients' capabilities and interests in order to customise activities. Such information can be obtained from residents themselves, their family and residential care staff. Tools can also help identify pleasurable activities; these include the California Older Person's Pleasant Events Schedule[54] and Pleasant Events Schedule – Nursing Home Version[55]. At the end of this chapter, we provide a copy of the Pleasant Events Schedule – Nursing Home Version, that was published in Aging and Mental Health by Meeks, Shah and Ramsey.[55]

Cognitive restructuring

Low mood and worry can relate to how a resident views events that occur in the facility. For example, a late shower may be interpreted as a sign that staff are upset with them, or they may worry excessively about their family members. Cognitive restructuring involves a discussion between a clinician and client about the client's automatic thoughts (e.g. thoughts or images that spontaneously are activated in specific situations), rules and assumptions, and core beliefs. Clients are encouraged to examine patterns of thinking (beliefs) that may be maintaining depression or anxiety. Once such patterns are identified, clients can then examine the extent to which such beliefs are accurate or helpful.

Often, more functional patients (e.g. community dwelling outpatients) are taught to question their beliefs by completing structured exercises such as daily thought records, answering Socratic questions (such as "what is the evidence supporting my belief?") and learning about cognitive distortions. Many aged care residents also appreciate such structured exercises and can feel a sense of achievement by learning cognitive restructuring skills. However, for others, these exercises are not feasible; residents may not be able to hold a pen or may not be able to see well enough to complete written exercises. Others may lack concentration or cognitive reserve to tolerate multi-step protocols.

Often, there is less reliance on structured exercises, particularly for aged care residents who are frail or have sensory problems or cognitive impairment. For those residents, experiential methods may help achieve cognitive restructuring. Consider the following example. A resident feels depressed, believing that her family does not care.

She tells you that they do not ever visit her. However, RAC staff note that the resident receives visits multiple times per week from family. The resident forgets about the visits, due to her poor short-term recall. Her evidence supporting her belief that her family does not care, is therefore factually incorrect. Instead of asking the resident to review the evidence for and against her belief, the clinician may instead arrange with RAC staff to install a whiteboard in her room, where visitors can log their visits and write a short message. With such tangible evidence of visits, the resident may revise her initial belief. Such creativity is often required with aged care residents.

The following is an approach that can be used to engage a resident in cognitive restructuring:

> *Discuss a situation that unsettles you. It may have been a recent thing or something coming up that you're uneasy about or not looking forward to. What are your thoughts or predictions about this situation? What do you think will happen? How do you think it will turn out?*

Discuss this together, focusing on identifying thinking errors and then, write down some thoughts that are more factual and help the resident feel stronger and more in control. Again, these are likely to relate to facts, rather than predictions.

> *For example: "I don't know what she's thinking"; "I can't see in the future". What are some things the resident could say to themselves that are more realistic? Discuss these together.*

Do not encourage the client to think positively. The goal of this technique is to help the client think in more realistic and helpful ways, not to substitute negative thoughts with positive thoughts – both of which may be equally unrealistic.

> *Ask the resident to focus on the FACTS of the situation: what is actually happening NOW? Compare these to the resident's original thoughts.*

In this cognitive aspect of treatment, it is important for you and the resident to notice the difference between the original thoughts and the fact, and then the emotional reaction to the original thought.

Use the therapy book (see Chapter 4) to write two columns: original thought and FACT/COPING, based on either the thoughts written down over the past week for homework or thoughts that may have come up in sessions. The task for the client is to write down thoughts that are more realistic or that help them feel better in their therapy book.

Structured problem-solving

Structured problem-solving exercises involve defining problems and goals, and brainstorming and testing solutions, all of which can be done in a structured and sequential manner. Clients can feel depressed or anxious because of the presence of problems that are unique to institutionalised care. For example, they may have impaired sleep due to loud noises at night, feel that care is not meeting desired standards, feel troubled by other residents who enter their room or want to return home. Often, residents can feel helpless and disempowered to solve such problems. Clinicians can assist residents define the problem, articulate a goal, brainstorm potential solutions and experiment with solutions that are considered feasible and potentially effective. The outcomes of such an exercise can be a greater level of validation, a greater sense of self-efficacy, and the emergence of practical strategies for achieving a goal.

Below are two resources for structured problem solving:

- **Six-step template for structure problem solving**
  https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/16-structured-problem-solving.pdf
- **This course provides a problem solving approach to address common challenges**
  https://www.veterantraining.va.gov/movingforward/

Exposure interventions

Exposure interventions are often used to help clients reduce anxiety associated with stimuli (such as animals) or situations (such as heights). Anxiety is maintained when a person avoids such contexts. Aged care residents may be exposed to novel situations, such as communal dining or having to use a lift, which can trigger anxiety. Exposure to the feared stimuli is usually conducted on a gradual basis. The client confronts less frightening stimuli before more frightening ones. In RACHs, exposure interventions can be useful to help residents reduce their avoidance behaviour. Residents may be afraid of falling, being in large spaces or being scrutinised by others. The role of the clinician is to identify situations that trigger fear responses, and then to design a treatment program to help the resident successively reduce their avoidance of those situations. Working systemically with staff and family is very important to maximise therapeutic outcomes.

The following case illustrates the use of exposure techniques.

A resident was afraid of walking from her room to the dining hall. Although the resident was ambulatory, she demanded that staff wheel her to the dining hall. Staff regarded her demands as unreasonable and "attention seeking." The clinician asked the resident about the reason for her demands. The resident explained that she did not feel confident walking unassisted from her room to the hall, because "if I fell, there would be no one to help me up." Over a series of weeks, the clinician accompanied the resident to the dining hall. First, the resident was physically supported by the clinician. In the next session, the resident walked ahead of the clinician but held on to the wall support handle. Gradually over several weeks, the resident was able to walk unassisted. The resident was also able to challenge her belief that help would be unavailable if she fell. She observed that the hallways were busy before and after meals, and hence, if she did fall, she would easily be able to seek help.

Distress tolerance skills

Distress tolerance skills training is frequently used in CBT. Such training serves to help reduce the physiological effects of anxiety, and to improve a person's sense of mastery over anxiety. There is a range of such skills that can be taught to residents, including breathing exercises, progressive muscle relaxation, guided imagery, mindfulness-based techniques, meditation, distraction techniques and self-talk. Sometimes, relaxation scripts are recorded so that the resident can listen to them when feeling anxious. Residential aged care staff can also be taught how to deliver these techniques to reinforce skills with the resident.

Below are several distress tolerance strategies:

- It is important to do this exercise at the first sign that you are getting tense (e.g. clenched fists, raised voice). First, get comfy, sit back against a chair, uncross arms and legs and focus on your breathing. Breathe slowly: In-2-3 and then out-2-3 as shown in the session. Try and think of a nice image from nature (for example, a favourite holiday spot) as you breathe easily and gently with no effort.
- **Deep breathing:**
  A common reaction to feeling anxious is breathing faster than usual and in a shallower manner (from chest, rather than stomach-trainee therapist to demonstrate). When we breathe in this way, we can feel dizzy and tense. It's important to notice this type of breathing, as it's something we can control with practice." See the following instructional video: https://www.youtube.com/watch?v=kRogdOOMw8I
- **The freeze technique:**
  "At the FIRST sign of feeling out of control and distressed, STOP whatever you are doing and FREEZE. TAKE A STEP BACK (yes, this is literal, go on and do it: it's like a dance) and then BREATHE SLOWLY. This gives you space and time to avoid getting into a panic cycle. Once calmer, you'll be able to think about the situation differently."

Reminiscence therapy

Prior to the 1950s, older individuals were discouraged from reminiscing, as retrospective reflections were believed to indicate poor mental health (e.g. senility). However, in the 1960s, Robert Butler proposed that memories, conversations, and reflections about the past can be helpful, not only for maintaining mental health but also for enhancing one's capacity to address current problems. Since then, therapists and researchers have been interested in using reminiscence as therapy.[56] There are now dozens of clinical trials showing that reminiscence therapy is an effective intervention for improving mood in older adults [57], including those living in RACHs.[58] Such therapy is employed across residential and community settings to foster emotional wellness among older adults. Reminiscence therapy has typically been employed in one of three ways:
Simple reminiscence, life review and life review therapy.

Below are webinars on using reminiscence therapy with older adults.

- **Reminiscence therapy**
  https://commons.swinburne.edu.au/items/49b03e9c-5606-49c7-840d-6506794183a9/1/
- **Reminiscence group work**
  https://commons.swinburne.edu.au/items/7a967bfa-9d8d-4d09-a086-6fa870e0d76c/1/

Simple reminiscence

Simple reminiscence aims to improve aged care residents' feelings of enjoyment and connection with others. The resident is encouraged to talk about memories that are "light-hearted" or that allow for a joint discussion about shared experiences (e.g. client and counsellor talk about the 'old days'). Often, items such as music or photographs or sensory experiences such as nostalgic smells [59] are used to prompt memories and discussion. In RAC settings, simple reminiscence can be conducted individually, or with groups - where participants are asked to share personal memories relating to particular topics, developmental stages, music, or memorabilia. For example, participants in a group may be asked to reflect on memories related to festivals, daily routines (e.g. walking to school), or important family occasions (e.g. birth of a child). In one of our groups, we ran an activity called 'questions from a hat', where participants would answer a question that was picked at random from a tall hat. In another group, we engaged the group to discuss topics that were thematically arranged every week (e.g. automobiles, neighbourhood). The primary aim of simple reminiscence in such groups is to assist individuals to engage socially with other group members and to enjoy telling, and retelling, stories about past enjoyable or important experiences.

Ask questions or use prompts such as:

- What is the story of your name?
- Play music or song from childhood and discuss associations
- Show photograph and share memories
- Discuss your first…kiss, pet, home, job…
- Discuss a favourite holiday and why it was meaningful (show map)
- Favourite childhood food
- Discuss a happy memory
- What were your favourite subjects at school?
- Who was a teacher who had a strong influence in our life?
- Tell us about your best friend.
- What was your neighbourhood like?
- What do you remember fondly about your childhood?

Life review

Life review involves a more elaborate discussion about residents' past experiences, with a view to understand the residents' values, pivotal experiences and identity.

In such therapy, clients are prompted to review the significance of their positive and negative experiences and to consolidate these into a coherent chronicle of their lives. Life review is more structured than simple reminiscence, in that it guides the resident to answer a series of questions about various stages of life (childhood, adolescence, adulthood) in chronological order.[60]

Whereas simple reminiscence can be delivered in a single session or with little continuity between sessions (e.g. each session comprises a different topic), life review often occurs over several sessions and focuses on memories about life stages in chronological order (e.g. childhood, early adulthood, mid-life adulthood).

Life review is typically conducted in one-on-one sessions with the resident, rather than in groups. Life review can help the resident arrive at insights into how they developed throughout their lives, to clarify the meaning of life, and to identify their values and personal identity, as reflected by past experiences.

For this type of reminiscence, you will be the interviewer. Ask the resident questions and draw out themes that may relate several experiences (e.g. “You have always seemed to see the best in people”) Ask question such as:

- What was life like for you as a child?
- What was your family like?
- What things stand out to you about being an adolescent?
- What was life like for you when you were in your 20s and 30s?
- What were the main difficulties you encountered in your adult years?
- On the whole what kind of life have you had?
- Did you live your life as you hoped to live?
- For your grandchildren listening in years from now, is there any wisdom that you would like them to know?
- What would you like to say to your younger self?
- What did you consider as the meaning of success when you were younger? What is success now?
- Were you in the military? What was it like? How did war change you?

Life review therapy

Life review therapy focuses the resident’s attention on specific positive memories. The goal of this intervention is to help residents construct a sense of self as efficacious and resourceful.

Similar to life review, life review therapy is usually conducted across several individual sessions. The clinician assists the resident to discuss past problem solving successes and to integrate difficult life events into a narrative that emphasises the individual’s agency. Clients are asked questions such as “Tell me about a time when you were able to solve a problem that showed your creativity”, “How were you able to cope with this situation?” and “What qualities did you show through solving that problem?”[61]

Once rapport has been built, you can ask for problem solving success. Enquire about a problem that the resident has managed to solve. Ask the resident how they solved it, and what they learnt about themselves as a result of solving the problem. Ask the resident questions such as:

- Think back over your life and try to remember a problem you solved. What was the problem, and what did you do to solve it? What did you learn about yourself? What are some lessons you have learned about yourself from challenges you have faced in life? Were you afraid of anything as a child that you are no longer afraid of? What have been some of the best decisions you have made in your life? What are you proudest of?

There is a growing research base for the effectiveness of reminiscence therapy.[57] Studies have found that life review and life review therapy are effective for improving depressive symptoms and emotional well-being in older adults. Some studies have found that simple reminiscence can also be effective for improving mood and for reducing loneliness in aged care residents.[50] Life review therapy also appears promising for reducing anxiety in older adults.

Life review and life review therapy can culminate in a written or recorded account of the resident’s life, such as life-story book, poster or short movie. Such records or recordings can then be shared with staff and family as a means of communicating aspects of the residents’ lives that may not be well known. Research has supported the finding that staff develop greater understanding of a resident’s background from such stories[62] which then has the potential of enhancing the person-centred care within residential aged care settings.[63]

Further resources

Pleasant Events Schedule – Nursing home version

Resident name: _____ Date of Initial PES: _____

Rate the following items according to whether they are now (or would be) a pleasant activity. Then rate whether they were **AVAILABLE during the PAST MONTH**, and then the **FREQUENCY with which you did them in the PAST WEEK**. Add other activities as appropriate on the bottom of the form.

Activity	Now pleasant 0=no 1=yes	Available past month 0=not at all 1=yes	Frequency past week 0=not at all 1=1-6 times 2=7+ times
1. Sitting, walking, or rolling wheelchair outside			
2. Reading or listening to books on tape			
3. Listening to music in your room			
4. Having someone read you something in your room, such as the newspaper, cards			
5. Watching T.V.			
6. Doing crossword, jigsaw, word games puzzles, etc.			
7. Talking on the telephone			
8. Doing handwork (crocheting, woodworking, crafts, drawing, ceramics, clay work etc.)			
9. Laughing			
10. Having a visit from family or friends			
11. Shopping or buying things			
12. Sharing a meal with friend or family			
13. Making or eating snacks			
14. Wearing favourite clothes			
15. Listening to the sounds of nature			
16. Getting or sending cards, letters			
17. Going on an outing (e.g. visit home, out to eat, visit to family/relative)			
18. Having coffee, tea or a drink with others			
19. Being complimented			
20. Being told I am loved			
21. Exercising (walking, stretch class, physical therapy)			
22. Going for a ride in a car			
23. Grooming (wearing make-up, shaving, having nails done)			
24. Having a shower or bath			
25. Recalling or discussing past events			
26. Participating in a group activity (e.g. Bingo, current events, Trivia)			
27. Attending religious services			
28. Listening to a musical performance (e.g. in dining room)			
29. Talking with another resident			
30. Watching others in hallway			

Chapter 6
Telehealth delivery of psychological treatments to residential aged care settings

Innovative interventions using technologies have been introduced in RACHs. Technology has been used to facilitate engagement and social connections as well as to facilitate psychological treatments. Such technologies have included electronic documentation, clinical decision support systems, safety technologies (e.g. monitoring systems), virtual reality, internet and touchscreens, robotics and video conferencing.[64]

As an example, in reminiscence sessions with residents, we have often found that technology and the internet are valuable resources for prompting memories and for engaging residents to talk about the past. For example, we have used applications such as “google maps” to assist residents recollect past experiences and contexts (e.g. where they lived). Similarly, we have streamed music on a tablet to enrich reminiscence about early experiences.[65]

Telehealth is feasible for many aged care residents – but it may require thoughtful set up and coordination with residential care staff and the resident. For example, can staff at the RACH support telehealth (e.g. do they have a device and someone to help set it up)? If face-to-face sessions are not possible (e.g. if we go into lockdown again, or the facility is quarantined), would the resident agree to continue sessions with telehealth or just pause therapy?

Reservations against using telehealth appear to relate to the assumption that care staff will not support such sessions and that residents do not want these sessions. While this is the case in some circumstances, it is not in many.

Due to the Covid-19 pandemic, many clinical services had to switch to telehealth to communicate with residents, and so, in many aged RACHs, there is a legacy infrastructure (e.g. iPads or tablets) and culture (staff being willing to assist set up video conference calls) that accommodates telehealth sessions.

The following observations are based on experiences of using telehealth to deliver counselling services to aged care residents across Australia.

Is telehealth feasible?

Telehealth is impractical when:

- residents have sensory, perceptual, cognitive or physical difficulties that limit their ability to communicate by telehealth.
- residents have very poor digital literacy
- residents are too frail to operate the technology
- staff are unavailable to facilitate telehealth calls
- there is weak internet connectivity
- there is a lack of access to equipment such as tablets or mobile phones.

Telehealth is feasible when:

- staff serve as 'telehealth champions' and are able to assist in setting up the hardware and showing residents how to use the video platform
- counsellors pre-arrange with care staff to make devices available, to help activate video platforms, or to prop up communication devices
- when staff are unavailable, family members can be recruited to assist with facilitating sessions
- the telephone is used instead of videoconference
- residents with difficulties holding a device can be encouraged to use a device holder (e, g. cookbook holders) to prop up tablets.

Here are case illustrations on how telehealth can be set up for residents:

Martha relocated to the facility due to declining physical health. Martha was unfamiliar with video call technology and was therefore unable to independently set up video calls. The manager nominated the lifestyle coordinator to assist with scheduling and setting up technology for sessions. The lifestyle coordinator arranged a computer tablet for Martha and introduced her to the counsellor. Having a staff member facilitate the setup of technology appeared to boost Martha's confidence in engaging via telehealth.

Beatrice, 84-years-old, experienced recurrent nocturnal panic attacks. She also had dementia characterised by short-term memory loss and confusion. The counsellor contacted Beatrice's daughter to obtain consent to speak with Beatrice. The daughter suggested that the counsellor speak to Beatrice while she was visiting her mother. The counsellor's first contact with Beatrice occurred via the daughter's mobile phone. Beatrice was unsure about the purpose of the call. She lacked insight into her anxiety and did not initiate conversation. However, with her daughter's assistance, she was able to talk about her childhood during 25 phone calls. Beatrice waited for the counsellor's questions and repeated the story. Beatrice often shared that she found the sessions 'pleasant.' Beatrice looked brighter suggesting that her feelings of being heard and validated endured for some time following the session. Beatrice also had fewer panic attacks at night.

Is telehealth private?

The lack of privacy is a concern in telehealth in two ways. Clinicians may be concerned that video conferencing is not secure and can be 'hacked'. Clinicians may be concerned that confidential conversations are overheard by others in the care home.

Several video conferencing platforms are available, with different levels of privacy settings and accessibility features. Some platforms are easier to use, but may fail to meet privacy standards, while others have stronger privacy protection but are more complicated to use. The choice of video platform is hence informed by balancing privacy and accessibility concerns.

A related issue is the lack of confidentiality in telehealth calls. Unlike onsite sessions, where the counsellor and resident can meet in private or have a confidential discussion without staff, it is more difficult to organise telehealth without staff involvement. At times, staff may be required to set up telehealth calls or be on 'standby' to assist residents to continue with video calls but need to respect residents' privacy during the session. To maximise residents' privacy while on a call, staff can be encouraged to leave the resident's room but be contactable by the counsellors by phone if needed. Counsellors need to be mindful of where they themselves are physically conducting sessions, as they may be working from their own homes. Counsellors need to ensure they have access to a private room or space from which to deliver counselling.

How is treatment adapted for telehealth?

Evidence-based psychological treatments for late life depression and anxiety in older adults have not been suitably tailored or systematically evaluated for telehealth delivery, with studies lacking research design rigour and generalisability.[66] Telehealth also makes it difficult to involve staff and families in delivering a systemic model of treatment to residents. Staff can be too busy with other duties to set aside time to work collaboratively with counsellors, hence, systemic work in this modality is not always feasible.

However, clinicians need not presume that staff are disinterested in helping with treatment. Some staff, despite being busy, see the value in co-administering psychological treatment and appreciate being consulted. Specific programs have been developed for staff involvement in delivery of psychological treatments.[67] When possible, videoconferencing tools such as online whiteboards and screen share, as well as online apps including Google Maps and YouTube can be used to engage residents to deliver treatment strategies such as reminiscence-based therapy.[68] Reminiscence therapy appears to be more easily augmented by images and maps online through shared screen functions, where both the resident and counsellor can interact with screen images and clips through the internet, strengthening therapeutic alliances and collaboration.

The following are illustrations of how treatment can be adapted to suit video platform-based calls and to incorporate staff in implementing treatment plans.

Darlene felt depressed and lonely. The counsellor used the screen sharing function to help the resident reminisce, accessing YouTube videos about Darlene's love of nature and music, and Google Maps to explore places she had travelled. The counsellor obtained photographs from Darlene's son and staff. These were then arranged into a life review booklet. Further, a staff member was invited to attend sessions to help facilitate behavioural activation. The staff member assisted her to complete a craft project between sessions.

Edward was referred because staff had observed that he looked depressed and was quieter than usual. He rarely received visitors and did not speak to others. Edward enjoyed reminiscing about his childhood and community life. The counsellor used Google's Street View to provide Edward a glimpse of his childhood neighbourhood. They also used Google Maps, images from Google searches, and material from websites such as Wikipedia and YouTube to prompt Edwards' memories and reflections about life.

Managing suicide risk by telehealth

Managing risk through telehealth is challenging. Awareness of risk factors such as isolation, depression, past suicide attempts, loss and changes in levels of dependency, can alert the clinician to possible suicidal ideation.[69] However, due to difficulties in timely access to client files or background information via telehealth, there can be less direct information available compared to an onsite assessment. Telehealth communication can be terminated by residents, so alternate forms of contact should be identified prior to commencing counselling. Despite such complexities, telehealth allows for increased access to mental health services for timely identification and treatment of risk factors such as depression in aged care residents. The need to ensure client confidentiality is balanced with considerations of duty of care.[70] The following case illustrates the importance of balancing duty of care with confidentially and carefully choosing whom to include in managing risk of suicide.

Fred was referred to the telehealth service because he was grieving for his wife, who had died 10 months prior. He had a history of depression and suicidal ideation and was feeling very isolated due to COVID-19 restrictions. Fred would only engage for very brief telephone counselling sessions; after 15 minutes, he would typically end the call. In one session, he disclosed that he had been stockpiling medication. He implored the counsellor not to tell staff that he had excess tablets. The counsellor decided to err on the side of duty of care, even if this would risk rupturing the relationship. The counsellor ascertained that Fred had a good relationship with a member of the senior nursing staff and informed this staff member. The staff member conducted a risk assessment and subsequently removed the medication. Fred expressed "disappointment" with this breach of confidentiality. However, he was satisfied that this breach had occurred with a member of staff he felt comfortable with. He continued sessions with the counsellor.

Telehealth counselling is predicted to remain a component of the mental health delivery framework for residential aged care. This delivery mode is projected to expand in response to government policies and programs to ensure accessible and equitable mental health services for nursing home populations. Telehealth can be delivered to aged care residents when clinicians adapt treatments to accommodate resident functional abilities, collaborate with aged care staff to help establish telehealth calls, leverage digital tools to prompt discussion and reflection and proactively follow-up on reducing suicide risk. Facilities can adapt their practices to support telehealth counselling service delivery through having designated staff telehealth champions facilitating calls and appointments. Working closely with staff appears to be a common factor in overcoming barriers to using telehealth delivered counselling sessions.

Chapter 7
Clinical challenges and issues

Despite the high prevalence of mental health conditions in RACHs and a range of evidence-based interventions for late life depression and anxiety, there are several factors that can block or complicate the application of psychological treatments services within such facilities. Further, issues related to cultural diversity, sexuality and intimacy can be complex to navigate.

Barriers to mental health care in residential aged care settings

Under-detection of mental health symptoms

Mental health conditions of aged care residents may not be detected by facility staff and visiting medical practitioners.[71] An Australian audit found that less than half of aged care residents with current major depressive disorder had a diagnosis recorded in their facility file or was receiving treatment.[72]

The poor detection of mental health symptoms may be due to staff or resident related factors. Staff are poorly trained in identifying and managing symptoms of poor mental health.[73] A substantial proportion of residential aged care staff view depression as a natural and expected consequence of ageing or relocation to aged care.[74] Further, medical practitioners may erroneously attribute symptoms of mental health disorders to physical conditions, cognitive impairment or age related frailty. They may regard problems with sleep, appetite and agitation as due to physical or cognitive conditions such as pain or dementia, rather than as symptoms of major depressive disorder.

Additionally, residents themselves may take a passive approach to health care, characterised by acceptance and dependency,[75] and may be unlikely to advocate for their mental health symptoms to receive appropriate attention. Commonly, aged care residents are aware of the time constraints affecting residential aged care staff and express concern about being a burden on staff.

Negative attitudes

Stakeholders (residents, staff, family and healthcare professionals) may believe that psychological treatments are not applicable or relevant to older adults, especially for those with multiple physical and cognitive comorbidities. Clinicians themselves may believe that older people are too old to change, or do not want ‘talk therapy’ and therefore may falsely label older people as unsuitable for psychological treatment.[76] In addition, residents may hold ageist biases regarding seeing a clinician.[77] They may have beliefs such as “I must be mad to see a shrink” and “I’m weak if I get help for my brain.” Such beliefs may preclude discussion of emotional issues and lower acceptance of psychological services.

Treatment approaches for depression and anxiety within RACHs are predominantly psychotropic medications.[78] Psychotropic medications can be inappropriately used in these settings to ‘chemically restrain’ residents who present with challenging behaviours – calling for a need for alternative non-pharmacological methods for supporting the mental health of aged care residents.[6]

Availability of clinicians

Aged care residents can have difficulties accessing psychological care, because of the limited availability of clinicians with specialised training and knowledge in working with older adults. Only 6 per cent of psychologists in Australia specialise in working with older adults.[79] Very few RACHs in Australia employ or contract mental health clinicians.[80]

Cultural diversity

Traditionally, RACHs have been structured around the management of chronic conditions and disabilities and have not attended sufficiently to the psychosocial needs of residents, and especially those from culturally and linguistically diverse (CALD) backgrounds. Programs designed to improve the cultural competency of residential aged care staff are essential to address disparities in residents' quality of life. Training in this area can be found here: https://www.culturaldiversity.com.au/

Furthermore, despite advances in adapting evidence-based treatment to accommodate older adults, there remains a dearth of evidence for how best to adapt such treatments to aged care residents from culturally diverse backgrounds, particularly when such adults are also living with physical and cognitive difficulties. The joint impact of culture (mainstream versus CALD), comorbidity (physical versus cognitive) and context (RACH versus community) on the effectiveness and implementation of evidence-based psychological treatments for late life psychological difficulties remains to be investigated.

Cultural safety for Aboriginal and Torres Strait Islander residents

Cultural safety is essential when supporting Aboriginal and Torres Strait Islander peoples in residential aged care settings and involves more than cultural awareness; it requires creating an environment where residents feel respected, safe and valued, and where their cultural identity is supported. For many, experiences of colonisation and intergenerational trauma have significantly shaped their relationship with healthcare services, leading to a lack of trust in these systems and making them hesitant to identify culturally.[81]

In some cases, mental health clinicians may not be aware that their clients identify as Aboriginal or Torres Strait Islander, as they may feel unsafe or unsupported in disclosing this aspect of their identity. For many Stolen Generations survivors, mainstream aged care services can resemble the institutional environments they were placed in as children, leading them to avoid these services. Instead, many survivors express a preference for home or community-based care, where they feel safer and more connected to their culture and family.[82]

Cultural safety is not an add-on or an additional consideration in aged care. It is a fundamental human right and a minimum standard central to Aboriginal and Torres Strait Islander people's sense of self. This involves embedding cultural safety into policies, care practices, and staff training. It's also about understanding the role of family, kinship, and community in the lives of Aboriginal and Torres Strait Islander peoples, as well as the right to maintain or strengthen their connection to Country, if that's important to them.[81] Clinicians should also reflect on their own cultural understanding and the impact this has on their practice.[83]

There is no one-size-fits-all approach to ensuring culturally safe care. Mental health clinicians need to respond to the unique needs and lived experiences of each resident. Whether it's connecting to Country, family or community, support should be flexible to support the diverse preferences of Aboriginal and Torres Strait Islander people.[83] Additionally, palliative and end-of-life care should be culturally appropriate, acknowledging spiritual practices and the significance of customs around death.[81]

Resources to support cultural safety include:

- **Department of Health, Disability and Ageing**
  Transforming Aged Care for Aboriginal and Torres Strait Islander People: A report outlining the unique needs of Aboriginal and Torres Strait Islander peoples in aged care and the importance of cultural safety
  https://www.health.gov.au/resources/publications/transforming-aged-care-for-aboriginal-and-torres-strait-islander-people?language=en
- **National Aboriginal and Torres Strait Islander Health Worker Association (NAATSIHWP)**
  Provides a framework to guide cultural safety strategies. natsihwa-cultural_safety-framework_summary.pdf
- **Australian Indigenous HealthInfoNet**
  A great source for evidence-based information on cultural safety and First Nations health. https://healthinfonet.ecu.edu.au/key-resources/health-professionals/cultural-safety-for-health-professionals/
- **Aged Care Quality and Safety Commission**
  First Nations Stakeholder Communications Toolkit: A practical toolkit for engaging and communicating with First Nations communities in aged care.
  https://www.agedcarequality.gov.au/resource-library/first-nations-stakeholder-communications-toolkit
- **Indigenous Program of Experience in the Palliative Approach**
  Provides resources and training to help healthcare workers offer culturally safe palliative care. https://pepaeducation.com/ipepa/
- **The Healing Foundation**
  A national resource supporting the healing process for Aboriginal and Torres Strait Islander peoples, with materials on trauma-informed care.
  https://healingfoundation.org.au/

Sexuality and intimacy

A common misconception is that older people are asexual; that they lack sexual appeal, sexual drive or desire. In reality, sexuality and intimacy remain important to adults over the age of 65 and can still provide physical and psychological benefits.[84] Residential aged care providers can compromise residents' ability to enjoy intimacy and express their sexuality. La Trobe University's Australian Centre for Evidence-Based Aged Care (ACEBAC) surveyed almost 3000 residential aged care facilities across Australia and found that sex and intimacy amongst its residents were often overlooked.[85]

Older adults can encounter ageist attitudes and stereotypes that impede their sexual expression. Sexuality in older age is commonly seen as a taboo topic, and consequently, older people may internalise this stigma and become less sexually active.[86]

Dementia does not eliminate the need for intimacy and companionship. Relationships may change, with individuals seeking new connections if they forget their previous partners. It is crucial to assess the capacity of individuals with dementia to make decisions about relationships and intimacy.

Closeness and intimacy are basic aspects of the human experience. Connection and the need for human contact matter. Not only do they make life worth living, but these ties also protect against depression and anxiety and offer us security, support and connectedness across our lifespan (Beyond Blue 2018).

With age, however, comes many significant changes to our lifestyle, such as the loss of a spouse or loved ones, physical decline and mobility issues, which mean maintaining social connections can become more difficult over time. Loneliness and social isolation are not inevitable, and new and existing friendships and intimate relationships can flourish with the right support.[87]

Intimacy refers to the emotional, affective and physical relationship between two individuals and how they connect (gentle touch, intellectual and emotional closeness, romance, intercourse etc.)

Sexuality refers to the way in which an individual experiences and expresses themselves as a sexual being (their biological sex, gender identity, sexual behaviours, sexual orientation, sexual activity etc.)

Many people find it difficult to talk about sexuality due to privacy concerns or discomfort. Mental health clinicians may feel uneasy discussing sexual matters with residents. Open dialogue is essential for understanding and supporting the sexual needs of residents. Clinicians and residential aged care staff can support the sexuality and intimacy dimension of residents by:

- Asking questions
- Reviewing policies in the RACH around intimacy and sexuality
- Providing non-judgemental care
- Supporting older people to dress and groom themselves in the way they would like to
- Considering privacy (e.g. provide older people with 'do not disturb' signs and always knock before entering someone's room)
- Referring older people to resources such as sexual health educational material and relevant health professionals
- Communicating with families
- Strategies such as providing double beds, connecting adjoining rooms and allowing overnight stays
- Using LGBTIQ+ inclusive language.[85]

Resources for clinicians

- **Sexuality And People In Aged Care Facilities**
  This document is a guide for partners and families of individuals living in residential aged care facilities, focusing on the importance of sexuality and intimacy for older adults, including those with dementia.
  https://www.dementiaresearch.org.au/resources/sexuality-in-aged-care/
- My Aged Care has developed a helpful resource for potential residents and/or their families who are looking to move into an aged care home, the 10 Questions to Ask brochure. It provides a list of questions that can help older people with diverse sexual orientation and gender identity including LGBTI find a suitable provider. The questions are written by doctors, nurses, and other experts with experience in aged care.
  https://www.10questions.org.au/
- LGBTIQA+ inclusive language guide. This guide explains how to use language respectfully and inclusively when working with and referring to lesbian, gay, bisexual, trans and gender diverse, intersex, queer, questioning and asexual people.
  https://www.vic.gov.au/inclusive-language-guide

Palliative and End-of-Life Care in Residential Aged Care

Palliative care is a core component of quality residential aged care, focusing on improving the comfort and dignity of residents with life-limiting illnesses. Mental health clinicians working in RACHs often support individuals who are approaching the end-of-life or who may die during their care. The goal of palliative care is not to cure the illness but to relieve symptoms, including physical, psychological, cultural, social, and spiritual aspects, manage pain, and improve the quality of life for residents and their families.[88] Currently, the median length of stay for residents who die in permanent residential aged care is approximately 21 months.[89] The Royal Commission into Aged Care Quality and Safety[6] emphasised that palliative care should be considered "core business" in residential aged care, ensuring that residents receive compassionate, person-centred care that respects their wishes and needs.

The National Palliative Care Standards for All Health Professionals and Aged Care Services[90] provide a comprehensive framework for delivering high-quality palliative care in RACHs. The standards emphasise that all healthcare providers who care for individuals living with a life-limiting condition must possess core competencies in palliative care and understand the palliative approach to care. It is essential that all staff, including mental health clinicians, are equipped to support residents with life-limiting illnesses.

Dignity Therapy

Dignity Therapy, developed by Dr. Harvey Chochinov, a Canadian psychiatrist specialising in palliative care, is a brief, evidence-based intervention designed to enhance psychological wellbeing for individuals nearing the end of life. This therapy enables individuals to address unresolved issues, reflect on their life's legacy, and discover meaning, thereby promoting a sense of dignity and reducing existential distress.[91]

For mental health clinicians working in residential aged care, Dignity Therapy offers a way to engage residents in meaningful conversations, allowing them to share their life stories, express their wishes, share memories and create a lasting legacy.

The following questions are core components of Dignity Therapy and are used to help individuals reflect on their lives:

- Tell me a little about your life history, particularly the parts that you either remember most or are the most important. When did you feel most alive?
- Are there specific things that you would want your family to know, and are there particular things you would want them to remember?
- What are the most important roles you have played in your life (family, work, community service etc.)? Why were they so important to you and what did you accomplish?
- What are your most important accomplishments, and what makes you feel most proud?
- Are there particular things that you feel need to be said to your loved ones, or things you would like to take time to say once again?
- What are your hopes and dreams for your loved ones? What have you learned about life that you would want to pass on to others? What advice, words or guidance would you wish to pass along to others?
- Are there words or perhaps even instructions that you would like to offer your family to help them prepare for the future?
- In creating this permanent record, are there other things you would like included?

Resources on palliative care

- **Dignity Therapy**
  https://dignityincare.ca/en/dignity-therapy-at-end-of-life.html#questions
- **palliAGED** is a comprehensive, evidence-based resource hub developed by Flinders University, offering tools, clinical guidelines and educational materials to support palliative care in residential aged care settings.
  https://www.palliaged.com.au/
- **ELDAC** offers a collection of practical tools and resources to support aged care providers and clinicians in delivering high-quality palliative and end-of-life care.
  https://www.eldac.com.au/
- **CarerHelp** is an online resource supporting family carers of individuals nearing the end-of-life. It offers practical information, tools and videos to help carers manage emotional, physical, and practical caregiving challenges.
  https://www.carerhelp.com.au/
- **Palliative Care Social Work Australia (PCSWA)** is a national association representing social workers in palliative, end-of-life and bereavement care across various settings, including residential aged care.
  https://pcswa.org.au/
- **CareSearch** is a national palliative care knowledge network that offers resources for healthcare professionals, including mental health clinicians.
  https://www.caresearch.com.au
- Webinar on end-of-life care and cultural diversity
  https://commons.swinburne.edu.au/items/55875ef8-43f4-421b-87fb-9a75bd312d08/1/
- **End of life and palliative care: What you need to know**
  https://commons.swinburne.edu.au/items/37e1b610-6437-472c-9811-236a217a541f/1/

Chapter 8
A model for adapting psychological approaches for long term care settings

Due to the multiple obstacles to the delivery of psychological services within RACHs, it is not surprising that residents do not widely use effective psychological treatments for mental health symptoms. How can such barriers be addressed? There are three suggestions for overcoming the multiple barriers to delivering psychology services in RACHs. Emphasise the importance of *engagement,* the use of *individualised treatment approaches*, and a *systemic model of care* that involves family and staff in the provision of psychological services to the resident. For a more detailed illustration of these elements, see a series of case studies,[92] a first person account of a clinician working in a RACH home[71] and a comprehensive list of guidelines on psychological service in RACH settings in the USA.[93]

Engagement

The engagement process in RACHs can take longer than that experienced in outpatient settings. Residents do not typically self-refer, but instead are referred by residential aged care staff, a family member or a medical practitioner. In some cases, the residents are unaware that they have been referred. In our experience, many residents who are referred to psychological services do not identify as having specific problems or needing assistance.

The initial focus of the clinician should be on developing a therapeutic relationship with the resident. Normally, such rapport can be built by engaging the residents in social discussion (e.g. while going for a walk), self-disclosure (i.e. the clinician discloses information about self) and an authentic demonstration of interest about the resident (e.g. asking resident about the contents of a photograph hanging on a wall).

It is also helpful for the clinician to be introduced to the resident by facility staff. The introduction is a 'bridge of trust' - where the staff member can invite the resident to extend the resident's trust from the staff member to the clinician. This introduction allows for a transparent handover, where the staff member can explain why the referral was made. The resident may then more readily agree to speak with the clinician.

At this point, the clinician can explain in brief terms who they are and what they might offer. Engagement can be improved by using non-technical language to explain the purpose of the sessions. Language is very important at this stage. Given the stigma that can be associated with seeing a mental health professional, and with revealing vulnerability, older adults may not respond positively to clinicians who use technical or official jargon when introducing the treatment. Instead of saying "I can provide psychotherapy", clinicians can introduce themselves in more generic ways such as "Your nurse asked me to talk with you to see if I can be of help", or "I provide support to many people in this facility' and "I wonder if we can chat to see if I can be of any help to you?". Some residents will want to know immediately about your credentials and intended action plans – which you can also provide succinctly and without jargon.

Early sessions with the resident typically do not focus on pathology but rather understanding the life circumstance of the resident. Goals and presenting problems can be unclear at this stage of treatment. Initial sessions may feel more like "friendly chats" rather than structured treatment sessions and clinicians may feel their expertise is underused. Clinicians new to working in RACHs may be concerned that they are being supportive, rather than using established psychotherapies. Earlier stages of treatment with aged care residents may often require non-directive interactions and a focus on the relationship (e.g. demonstration of empathy), compared to later stages of treatment.

Individualised treatment approaches

Once therapeutic trust is established, the client may begin to reveal more about their problem, and more formal treatment strategies may be more acceptable to the client. At this stage, clinicians are encouraged to develop an individualised, evidence-based treatment plan for the resident that accommodates a psychological conceptualisation of the resident, their individual preferences and needs, and possible physical and cognitive comorbidities.

The psychological conceptualisation of a RAC resident is the clinician's understanding of the resident's problem/s, treatment goal/s and factors that maintain the problem. Treatment can be considered a method for helping clients overcome obstacles to reach goals. Three helpful questions that a clinician should try to answer in order to provide direction to therapy are: (1) "What is the problem?' (2) 'What is the goal of treatment' and (3) "What is maintaining the client's problem?' Each question can take time to answer, as residents may not be able to answer any of these questions. Hence, such questions may need to be explored from the perspective of the resident's family or staff.

Learning about obstacles to the goal is especially important. For example, a RAC staff member may refer a resident for psychological treatment of depression. According to the staff member, the resident rarely joins social activities that are organised by the facility lifestyle department. After meeting with the resident over several sessions, the clinician learns that the resident feels disinterested in the selection of activities available at the facility. Rather, the resident enjoys art. The resident agrees that she would prefer to engage in activities that relate to this interest. The clinician collaborates with the RAC lifestyle department to organise social activities that involve art. This treatment method involves an evidence-based intervention (behavioural activation); however, the key to its success is understanding the obstacle to the resident being more social, which in this case, is the poor choice of activities.

Individual preferences and needs of residents should be considered when planning treatment. Clinicians can customise treatment to address residents' prior experiences with treatment, preferences, personality and culture. Asking about residents' *past experiences with treatment*, can help clinicians refine the treatment approach. For example, a resident may state that prior experiences using relaxation training were ineffective; hence they do not want to re-engage with such treatment. However, on further inspection, the clinician may learn that the resident was incorrectly using relaxation techniques and therefore can design current treatment to correct the technique. Clinicians may present residents with a *choice of interventions and ask* for their preference. For example, the clinician might say – "You can feel less anxious by learning mental skills or relaxation skills. What appeals to you most?" The answer will help identify interventions that are preferred by the client.

Interventions should also be tailored to *accommodate physical frailty and cognitive impairment*. For clients who are frail and tire easily, treatment sessions are likely to be shorter. For residents with cognitive impairments, treatments are likely to involve strategies to compensate for memory impairments (e.g. using memory aids, involving others in the treatment and using simpler and more concrete strategies). For example, a resident with memory difficulties may benefit from a therapy book (see chapter 5) where key messages and strategies from each session are written down for the resident to review.

The clinician can also consider the *client's personality and preferences*. A client may be uncomfortable in large groups, suspicious of other people's motives or unassertive in expressing their likes and dislikes. The clinician can modify interventions to respond to idiosyncratic characteristics. For example, for residents who are suspicious, the clinician may need to clearly explain the basis for tasks. For residents who are uncomfortable in social situations, treatment may involve one-on-one rather than group-based activities.

The clinician needs to be sensitive to the cultural backgrounds of the residents in order to provide culturally responsive therapy – that is, to adapt evidence-based treatment such as CBT to be culturally congruent. For example, some residents may feel angry towards their family for violating cultural assumptions that families will take care of older adults. These residents may not want family involved in collaborative care plans. Others may present as overly obedient towards health care professionals, reflecting cultural assumptions about authority.

Such residents may not be willing to openly disagree with the practitioner but instead may passively avoid sessions. The clinician needs to try to learn about the persons' cultural background, in order to respond to preconceived biases and to establish a therapeutic working relationship with the resident. Doing so also enables the clinician to educate staff about the cultural identity of their residents. Such actions promote a more inclusive and responsive environment to meet the needs of aged care residents from diverse backgrounds.

Systemic model of care

A systemic model of care involves a shift in therapeutic focus from an individual level to an organisational level. A systemic approach shifts the structure of treatment from a one-to-one model (practitioner-resident) to one that also involves the residents' family, health care staff and specialists. It can be helpful to involve residents' professional and family carers in psychological interventions in three ways – as a resource for information, as collaborators in treatment, and as recipients of education and support.

Information that is required for a psychological conceptualisation of residents can be *sourced from others*, including facility staff and family members. Nursing staff in many RACHs can collect information to help the clinician understand why the resident is displaying a particular behaviour at a point in time. Such information may include antecedents ("A") or triggers, objective description of behaviours ("B") and consequences ("C") or what happens after the behaviour. The complexity of presentations necessitates an interdisciplinary team approach. For example, knowledge about the resident's usual habits and preferences for daily care can explain reactions to changes in routine.

Clinicians may need to *invite others to collaborate in treatment* to successfully achieve treatment goals. The role of family and friends in this case is as collaterals, where their function is to support the treatment. A protocol for how others can be involved in treatment in this way is found in Paukert and colleagues.[94]

The following case illustrates a systemic model of care that involves both family and staff in reaching a positive outcome for the client.

A family member (daughter) has asked you (the clinician) to assist her mother who is living in a residential aged care home. The daughter says that her mother has been quiet – rarely wanting to talk by phone the past month. Over the course of counselling, the mother tells you that she feels ignored by her family. She says that her daughter is ignoring her because she does not visit as frequently as previously. With the mother's approval, you organise a three-way conference call with the daughter and mother so that the mother can share how she feels. The daughter tells her mother that she has stopped visiting because of the visitation restrictions imposed on families by the facility as part of the facilities' COVID-19 infection control policies. However, her mother remains confused about why the facility would impose such restrictions, and wonders if the daughter has misinterpreted the rules. The counsellor, mother and daughter decide that it would be useful to clarify the rules by speaking with the facility care manager. The counsellor organises a four-way conference call to link the care manager with the daughter and mother. The care manager clarifies the rules. The daughter learns that in fact she had misinterpreted the severity of the rules; visits were permissible but with conditions and on a limited basis. The mother feels reassured that the reason for the reduction in visits was due to the restrictions.

As demonstrated, the treatment approach goes substantially beyond a one-to-one session with the resident. Instead of providing reassurance to the resident, or in attempting to help the resident feel better through pleasant activities, the treatment involves a more concrete attempt to resolve perceived misunderstandings between the resident, family member and facility staff.

A further element of the systemic model is to *provide education and support to the residents' family and staff*. The premise in this approach is that by nurturing the residents' care system, the resident will receive better care, which will impact positively on their mental health and wellbeing. For many families, the experience of their loved one transitioning into a RACH is stressful and distressing, and can be associated with family conflict, particularly if the admission was against the older person's wishes. Yet there is little formal support provided to family carers in managing the transition to care. Clinicians can play a pivotal role in supporting families by normalising their responses, providing education and facilitating communication between families and staff. For example, families who feel guilt, ambivalence, fear and grief may require high levels of support and reassurance when placing a loved relative in care. High quality examples of such models of support are Quall's Caregiver Family Therapy.[95] and Gaugler' s Residential Care Transition Module.[96]

It has been observed that feelings of loss and guilt and a poor understanding of an illness trajectory can sometimes lead to conflictual relationships between families and staff. Families may blame staff for not adequately caring for their loved one. Families may not understand the effect of dementia on behaviour and therefore, may feel angry when observing changes in their loved one, mistakenly attributing these changes to poor staff care, rather than to the illness. In this case, the clinician can provide information to families about the resident's condition. As an impartial health care provider (i.e. not employed by the facility), the clinician also can facilitate communication between families and staff so that perspectives can be shared and explored. Such support can be provided individually or through group work.

The Wellbeing Clinic for Older Adults has run an online group support program for families through Zoom. The program was well attended, highly acceptable and beneficial.[97] Watch a webinar about this program here: https://commons.swinburne.edu.au/items/f23f7836-43a5-49d3-bdf9-8a80bcff9da1/1/

Facility staff also require education and support. Education can be provided to staff through sharing ideas and successful strategies at group forums, such as clinical handovers (so as not to place additional time burden on staff), or through more formal training sessions. Mental health clinicians can also help develop protocols for routine screening and referral to increase the rate of referrals of residents to mental health practitioners. Education and protocols may assist staff to not only detect mental health symptoms in residents, but also to refer residents for treatments [98]. Clinicians are also in a position to provide information about the cultural background of the residents and hence to improve cultural competence of staff.

Residential aged care staff also require support and assistance in responding to residents who are suicidal, agitated or distressed. Staff can experience significant stress when confronted with behaviours such as aggression. Staff who are overwhelmed by behaviours may inadvertently increase them, adding to resident disability. A common staff perception of challenging behaviours, such as repetitious calling out, is that it is done "on purpose". In fact, such behaviours are rarely under the resident's direct control. The clinician has a critical role in providing education regarding the function of such behaviours.

The role of the mental health clinician in such settings is thus expanded from that of a practitioner offering one-on-one care, to one who is working with the system requiring flexibility in roles - practitioner, advocate and consultant. The following case studies illustrate how clinicians can work effectively with aged care residents presenting with a range of mental health issues.

Chapter 9
Bringing it together

In this section, issues discussed above are pulled together to highlight how clinicians may work innovatively with aged care residents with different mental health conditions, using a systemic model of care. In each of the cases below, the complexities that may emerge are highlighted and opportunities for effective and innovative practice are suggested.

Bill was a 90-year-old widower who was never the same once he moved into aged care. Once the life of a party, he now looked solemn and rarely spoke. He had two daughters who visited regularly, but the visits were empty - there was less to talk about, and the grandchildren rarely visited. Bill moved into care following a series of falls at home. His wife had died a year before his move, and his daughters decided that it was best for Bill to move into supported care. Bill was not exactly against the idea - he was practical; but he was not happy to move away from his home to the facility. He saw himself as a 'private man' and was uncomfortable sharing too much about himself with others. He often preferred to stay in his room, and once, when talking with an aged care personal care worker, he revealed that he was not sure what life was all about. This statement along with his unhappy demeanour prompted staff to refer him for counselling. He accepted the referral, although he was unsure why he was referred or what counselling could achieve to change the reality of his situation.

This case raises several questions. First, what is the severity of his mood symptoms? How can such symptoms be assessed? Was his statement about the meaninglessness of life indicative of suicide ideation, death ideation or hopelessness? Second, how can the clinician engage Bill, when he has not sought help, nor understands the potential benefits of such help? Third, how might the clinician tailor treatment? What information might help develop a treatment strategy? Fourth, what strategies may help? These are the types of questions that clinicians face when attempting to deliver services to aged care residents.

The assessment of depression is accomplished through interview and psychometric approaches. Aged care residents may have completed previous surveys on depressed mood. In Australia, on entry to aged care, residents are administered the Cornell Scale for Depression in Dementia[99]. However, such scores are often outdated and hence may not reflect the client's current presentation. Hence, clinicians would need to update such measures. Usually, the assessment of depression starts with an interview, where the clinician asks the client about their mood symptoms over the previous two weeks. It is important to attempt to separate symptoms of depression that may be attributed to other causes. For example, while sleep and eating problems are common for people who feel depressed, such symptoms also occur because of other reasons (e.g. pain, difficulty swallowing etc.).

Given that older adults are less likely than younger adults to report affective symptoms, it can be helpful to obtain observations from others such as family member or staff informant. There are also a range of measures that the clinician can use to supplement these interviews, which may help distinguish affective symptoms of depression from dementia and physical illness[100]. Several of these measures also contain items that allow for a specific assessment of suicide versus death ideation. However, directly asking the question "Have you thought about taking your own life?" can be equally clarifying.

Engagement is not completed in a single session. It is important that the clinician continues to engage the resident throughout treatment. A request to revisit the resident such as “would it be okay if I dropped in next week to see how you are doing?” is rarely rejected by residents who feel isolated. It may be important to keep sessions somewhat informal during the engagement phase.

Conceptualising maintaining factors for depression is central. For Bill, it may be that he feels bored or uncomfortable in large groups. It is possible that he does not feel he has any purpose or agency or has a diminished sense of personal identity. By knowing such factors, the clinician can then develop a treatment plan and implement strategies to address such factors. For example, behavioural activation may be developed to help reduce boredom. Life review may be used to help Bill develop a greater understanding of his life, as well as a chance to reflect on his losses and gains over life.

The clinician may also work with Bill’s family – specifically, his daughters – to help them have more meaningful conversations with their father. There are a range of resources that may help make such visits more meaningful. For example, the Alzheimer’s Society of Canada (see weblink at end of chapter) has a helpful list of ‘tips’ for visitors. Such tips include bringing along a pet, photographs, videos and letters, and engaging in activities that are enjoyed by the resident. Dementia Australia has created a free to download app featuring a range of two player games designed to enhance communication and social interactions between visitors and residents (see weblink at end of chapter). Although such resources are designed to be used with residents living with dementia, they can be adapted for residents without dementia. For example, the daughters may embark on a project to record Bill’s life story, using questions from Storycorp.org. That website and associated app provide a list of questions and methods to facilitate such recordings.

Suicide ideation

Brian was an 80-year-old gentleman who was recently admitted to the RACH home, after previously living at home with his wife of 50 years. He had two adult children and four grandchildren who were well settled and busy with their own lives. Brian had a chronic medical condition, and six months prior to the admission, had been told he had a life expectancy of only a few months to a year. Following this prognosis, Brian had two serious suicidal attempts resulting in admissions to an inpatient aged mental health unit. Since he was admitted to the RACH home, Brian refused to eat. Brian was receiving anti-depressant medication. He used to be religious but had not been practising for many years. He did not want to be a burden to his family and often declined their visits as he felt he had nothing to offer them. The increased isolation allowed more time to ruminate over his life and think about regrets. He did not think that anyone could help him and therefore “pushed” away others who showed him kindness or care. Staff referred him to a clinician to be involved in his care.

In such circumstances, staff can feel ambivalent about whether a referral is indicated. After all, Brian is facing a terminal chronic physical health condition and hence has a limited time to live. Surely, hopelessness would be normal during this stage. Further, refusing to eat may not be perceived by staff as constituting a suicide attempt, as such behaviour does not conform to traditional stereotypes of suicide methods (as reviewed above). Such ambivalence can deter referrals of individuals such as Brian, resulting in missed opportunities for seeking further assessment and treatment. Hence, as a clinician referred to work with Brian, it might be helpful to reassure staff that such referrals are indicated as it allows for a thorough assessment of his symptoms.

Given his medical condition, Brian may only tolerate short interactions. Initial sessions may be short (e.g. 10-20 minutes) and frequent. As the RACH home is a new setting for him, it may be useful to ask him if he would explore the facility together. Such activity may enable him to become more familiar with his surroundings and more accustomed to visits by you. Pertinent at this point too would be to explain your role as a clinician, what you hope to provide, and how you would like to work with Brian in a collaborative manner.

Brian may in fact want to know how you can assist him, and it would therefore be useful to be able to articulate your role. It is often useful to convey an openness and exploratory approach such as “I’m interested to learn how I can be helpful to you – would it be okay if I came by to visit for a few minutes?”

Building rapport and showing a genuine interest in Brian may provide the opportunity to then learn more about his life and to conduct some more formal assessments. After two serious suicide attempts in six months, it would be important to assess his continued suicidal risk with a view towards developing a suicide safety plan. As trust develops in the therapeutic relationship, Brian may be more willing to disclose issues such as a fear and anxiety around death. He may want to reconnect with religious beliefs and traditions or better understand his medical condition. He may also have unresolved tasks that he hopes he can complete before death. The clinician may assist Brian to speak to a pastoral care member and participate in chapel services. Using questions from dignity therapy,[91] the clinician may also assist Brian to undergo a brief life review, and to generate a written document of his life lessons. Through the recounting of past experiences, values and wisdom, Brian may feel a sense of purpose.

A structured involvement of family may also feature as part of the psychological intervention. Given Brian’s reluctance to eat, the timings of family visits could be structured around mealtimes. Giving him company may act as a distraction for him to try some of his meals. Family could also tailor some of his meals to include his favourite food which may help break the cycle of not eating at all. Daily care activities may be scheduled to coincide with family visits, to enable the family members to assist staff.

Mrs Brown, an 82-year-old aged care resident was diagnosed with Dementia of the Alzheimer’s Type and congestive cardiac failure. She spent all her day in her room, refusing to attend meals. The staff asked the clinician to see her to “address her non-compliance”. On assessment, the clinician noted that Mrs Brown was lying in bed with the covers pulled nearly over her head. When encouraged to pull the covers down so her face can be seen, Mrs Brown was breathing very shallowly and rapidly; she presented as frightened, restless and very irritable. She refused to sit up in bed and asked the clinician to leave the room. On speaking with the clinical team during afternoon handover, the registered nurse remarked that she appeared to be more comfortable when she had a cup of coffee every morning.

Mrs Brown’s situation highlights several unique aspects of delivering treatment for cases of anxiety in residential care. As Mrs Brown’s referral from staff to improve “compliance” demonstrates, understanding anxiety also requires a cultural shift away from blaming the resident and their undesired behaviour, to addressing the individual resident’s needs. This may appear daunting for novice practitioners, given the complexity of some presentations; however, a comprehensive assessment often can indicate potential intervention entry points.

Screening for factors such as delirium is important for all referrals for mental health assessment, as an older adult’s symptoms may be due to an undetected delirium. Treating delirium can result in dramatic improvements in behaviour and physical and mental wellbeing. Symptoms such as poor concentration, motor restlessness and fear are common to anxiety and delirium; however, the acute and fluctuating nature of confusion in delirium is a key difference to consider.

As previously described, a unique aspect of conducting therapy within RACHs is the importance of actively including family and staff in delivering the treatment. The family and RAC staff are key allies in not only identifying potentially treatable issues, but also in implementing treatment strategies. For example, the family may be able to share information about Mrs Brown to allow for a diagnosis of generalised anxiety disorder (“Mum has been nervy all her life; she constantly worries”). They may also reveal strategies that helped Mrs Brown‘s anxiety in the past (e.g. simple slow deep breathing). A careful history taking and incorporating such information into care plans is essential.

Such strategies can then be shared with RACH staff resulting in their consistent application. For example, the clinician can provide staff information about anxiety and suggests that staff assist Mrs Brown use deep breathing as a coping skill.

"Brainstorming" sessions with staff can be highly useful in staff moving away from feeling helpless to actively solving a problem, and in achieving 'buy-in' from staff to commit the time required to assist the resident. In this case, the RAC team may decide that a member of staff would share a cup of coffee with Mrs Brown every morning, gradually encouraging her to sit on the side of the bed and increase her mobilisation. Activities that Mrs Brown enjoys may serve as a means of gradual exposure to leaving her bed. Staff would also assist Mrs Brown engage in relaxation to manage her anxiety (e.g. simple slow breathing exercise).

The mental health clinician can meet with the team weekly during handover to review her progress. By better understanding Mrs Brown's anxiety, staff may change their view of Mrs Brown from "non-compliant", to a person with individual needs and interests. Living with dementia does not preclude a person from a diagnosis of anxiety, nor should it deny them access to potentially effective treatments. Through a coordinated effort by the clinician, family and staff, Mrs Brown may gradually be able to leave her room and attend activities she enjoys such as gardening group and church services.

Personality disorder

Mrs Wheeler was a 70-year-old lady who had been in the RACH for just over 18 months. When she arrived at the facility, Mrs Wheeler appeared passive and mostly kept to herself. Except for short conversations with staff, Mrs Wheeler did not really associate with the other residents or make new friends. Mrs Wheeler would sometimes come to activities but remained quiet unless she was asked a direct question. Staff attempted to engage with her, but she mostly just smiled back. Her family members were concerned, as she often ignored their calls and when she did talk to them, she told them that she had not been eating or able to engage in activities and had swallowing difficulties. She did not think that she "fit" into the facility and exclaimed that she was "better off gone". Her family became increasingly distressed and made calls to staff to check on their mother. Staff were unsure how to manage the family's concerns as Mrs Wheeler did not show any outward distress to them. Some staff saw Mrs Wheeler as pleasant and easy to work with. Others noted she could become "nasty and dismissive". On some days, she stayed in bed and refused to come out for meals or activities. Staff did not understand these fluctuations in her mood and were confused about how to respond to her. The anniversary of her husband's death was approaching, and staff were concerned, given that she attempted to tie a plastic bag over her head at the same time last year. Mrs Wheeler previously hoarded some of her medication and took an overdose when her son forgot to call her on her birthday. Mrs Wheeler was being treated for chronic pain and depression but otherwise was considered healthy. A referral was made for a clinical clinician to see her and provide some recommendations.

Personality disorders (PDs) among older adults living in RACHs are not always recognised. Instead, residents with such disorders are typically treated for their depression, anxiety or psycho-somatic symptoms, without their underlying personality features explored or addressed. The resistance, avoidance, withdrawal behaviours and difficulties with engagement can often be dismissed by staff as inconsequential, until a crisis ensues. Features of many PDs, such as emotional dysregulation, insecure attachments, and dysfunctional schemas are pervasive across the lifespan.

In Mrs Wheeler's case, it would be useful to hear the collateral history from her family, in order to understand how best to engage with her, and how to help her stabilise emotional dysregulation.

The clinician may learn that Mrs Wheeler responds best to validation and structured programs. With such information, the clinician might attempt to engage Mrs Wheeler by validating her distress and collaboratively setting goals to improve her quality of life within the RACH.

These goals may include learning to self-soothe, learning mindfulness based grounding techniques and establishing a more predictable communication pathway between herself and staff, particularly when she does not think that her needs are being met.

It will be important to gradually facilitate Mrs Wheeler to attend groups and to interact with other residents in a small group. It will not be unusual for Mrs Wheeler to avoid meaningful relationships as an avoidant strategy to prevent grief, loss, rejection and/or abandonment. Her internal working model of how she perceives relationships, and the world may influence how she navigates this new environment. It is therefore important to allow her to experiment, build on learnings and be positively reinforced for constructive behaviour. She may avoid feeling positive, happy and fulfilled in order to take on the sick role for continued attention. It is important that therapy facilitates acknowledgement of these feelings as part of shifting of her emotional experience of life and building on her values of what she would like to hold on to.

Working with someone like Mrs Wheeler can be considered as medium- to longer-term therapy work. Depending on how she engages, this can be broken down into goals or addressing different aspects of her presentation. While CBT has been used with older adults in the community, older residents within a long-term care facility often do not have access to longer term therapy interventions.

Hence, a systemic approach to therapy would therefore involve providing staff education about dysfunctional behaviours, relational patterns and the impact of these on the staff team, as well as strategies for managing such issues in order to reinforce therapeutic goals. Such information may help staff reframe Mrs Wheeler's behaviours as signals of unmet interpersonal needs for love, security and stability. A set of instructions for the staff would help staff respond to such needs in a consistent manner.

Chapter 10
Conclusion

As shown, there is much that mental health clinicians can offer older adults living in RACHs. There are roles for clinicians to play in educating staff about mental health symptoms, in helping to develop screening systems, and in working therapeutically with clients and their networks in a systemic manner. Clinicians often require sensitivity and skill when engaging clients who do not self-refer or fully understand the services being offered. Using technology to enhance therapeutic goals is an emerging area of development, not only for delivering services by telehealth, but also as an adjunct to treatment. As many of us will require supported care in some way if we cannot function independently, it is timely that clinicians develop greater competencies in clinical geropsychology, so that they can support the mental health needs of aged care residents, currently and into the future.

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