Psychology in Aged Care: RACF Placements

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Introduction

The Psychology in Aged Care submission will elaborate on the Pre-Budget Submission of the Australian Psychological Society (APS), in particular, the suggested support for the piloting of a program of training and supervised clinical placements of psychologists in residential aged care facilities (RACFs).

In particular, the submission aims to increase the access to high quality psychological interventions for clients in RACFs. It would also alleviate the critical shortage of placement opportunities for postgraduate training programs, provide increased career opportunities for professional psychologists working in aged care and, by extension, attract more psychologists into the sector.

Specifically, this project will fund the development and management of a supervision program for psychology student trainees who are undertaking postgraduate professional training through courses in Clinical Psychology, Health Psychology, and Neuropsychology. This would increase access by both clients and staff of RACFs to the interventional and consultative opportunities offered by such psychology students.

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

- Non-drug interventions for behaviour management that can be less disruptive and just as effective as medication;
- Proven non-drug interventions for patients with mood disorders (e.g., anxiety, depression) and general distress;
- Strategies for better understanding, management and potential prevention of disruptive behaviour by RACF staff;
- Chronic disease interventions that can both reduce symptoms and improve adherence to treatment programs by residents while decreasing the incidence of associated distress in both residents and carers.
- Work in collaboration with medical staff in the accurate diagnosis of mental health or neurological conditions;

Evidence-based and cost-effective interventions

The incidence of psychological disorders is at much higher rates in RACFs than in the community (Rovner et al., 1990). There have been several studies into the mental health status and well-being of older adults who are residing in long-term care facilities. In one study prevalence of any psychiatric illness was 76.3% at admission to a RACF (Wancata et al, 1998). After dementing
conditions, depression and anxiety are probably the most common psychiatric conditions in nursing home residents (e.g. Smalbrugge et al, 2005). Anxiety symptoms have been estimated at approximately 30% of nursing home samples (Smalbrugge et al., 2005). Studies in Australian residential care facilities have found the prevalence of depression was 32% (Anstey et al., 2007). These are significantly above non-institutional or community prevalence rates. All of these researchers have suggested that risk assessment and targeting of intervention strategies to prevent depression and anxiety in late life should be a priority, and should target improving functional capacity and well-being, areas in which psychologists are well-placed to offer their expertise.

Currently these problems are commonly treated with psychoactive medication which is expensive, frequently has undesirable side effects and requires regular adjustment in order to deal with issues relating to poly-pharmacy. There is also an extensive literature showing that staff in these facilities, who routinely undertake extremely difficult and emotionally fraught care tasks, are often stressed and relatively unsupported, which affects quality of care (Edberg et al., 2008; Evers, Tomic, & Brouwers, 2002; Moniz-Cook, Woods, & Gardiner, 2000).

When pharmacological treatment is supplied for the behavioural disturbances, which are very common in residential care, the medications used are frequently inappropriate or ineffective (Ramadan, Naughton, & Prior, 2003). Meta-analyses over the last two decades have repeatedly shown that anti-psychotics, the most common intervention, have modest efficacy at best and frequent side effects (Schneider, Pollock, & Lyness, 1990; Schneider et al., 2006; Sink, Holden & Yaffe, 2005). Psychosocial interventions in aged care services are shown to be effective (Cohen-Mansfield, 2003; Opie, Rosewarne, & O’Connor, 1999), and cost significantly less than conventional forms of treatment.

An Australian example is a multi-disciplinary trial funded and published by the Commonwealth Government (Bird, Llewellyn-Jones, Smithers & Korten, 2002) and led by a clinical psychologist. Psychotropic medication was used in a minority of cases, but most cases employed a mix of psychosocial interventions tailored to the individual needs of the case. Over the course of the trial, only one patient was hospitalised (for a total of two days) compared with more than 20% (total hospital days 93) of a control group which was treated mainly with anti-psychotics. Drug side effects were reported in 12 cases in the psychosocial group, and in 32 cases in the conventional treatment group - a threefold reduction. Visits by general practitioners to deal with behavioural problems were reduced by half, an average of 4.5 visits in the psychosocial group, and 9.4 visits in the conventional treatment group. Visits by consultant psycho-geriatricians were also less common, an average of 1.2 visits in the psychosocial group, as against 4.8 visits in the conventional care group. Use of anti-psychotics declined in the psychosocial group and increased in the control group.
Similar trials, all led by clinical psychologists, are now being reported in the international literature (Bird, Llewellyn-Jones, Smithers & Korten, 2007; Cohen-Mansfield, Libin & Marx, 2007; Davison et al., 2007; Fossey et al., 2006). The case-specific approach is essentially the method advocated by the Commonwealth Government in the Dementia Behaviour Management Advisory Services programme (DBMAS), which was co-authored by a clinical psychologist.

Contributions by specialist psychologists in aged care can also lead to increased overall cost-effectiveness of interventions through decreased reliance on medications, or their more focussed use. For instance, the introduction of effective drugs for cholinesterase inhibition, such as Aricept®, and the placing of these drugs on the Pharmaceutical Benefit Scheme (PBS) has led to a substantial increase in the quality of life of an older person with dementia that is caused by Alzheimer’s disease, as well as an increase in the length of time in which a person can remain at home in the community.

Correct diagnosis is of vital importance as these medications will only work in cases of Alzheimer’s disease, very likely benefit in cases of mixed dementia involving Alzheimer’s disease, but not other in forms of dementia. One of the main diagnostic tests used in prescribing patients with such medication is the Mini-Mental State Examination (MMSE) (www.pbs.gov.au), which is known to have significant variations in the procedures for its administration and scoring that affect the end score. Misdiagnosis through inappropriate administration of MMSE is less likely to occur with proper training of physicians and others who administer them. Such training could be provided by experts in the field who are familiar with the standard forms, including neuropsychologists, who are well versed in methods of assessment. This will lead to reduced rates for misdiagnosis, thereby increasing the effectiveness of the medication and the overall cost effectiveness of therapeutic interventions.

The consequences for a lack of provision of adequate psychological services for older adults can be profound. For example, a recent study in the UK found that 80 per cent of older adults who were suicide completers had received no referral to mental health services, and 15 per cent completed despite being under a psychiatrists’ care (Salib & El-Nimr, 2003). In this study, among those who had successfully committed suicide, older males and older adults who were widowed were less likely to be known to mental health services. Similarly, within the framework of the World Health Organization (WHO/EURO Multicentre Study of Suicidal Behaviour), results showed that older attempters were characterized by a much higher rate of female attempters, hard methods (especially among older males), and higher proportion of depressive and organic disorders. The authors point out that “the recognition and treatment of depression plays a very important role in suicide prevention in the elderly population, and adequate emotional and psychosocial support by family and health care systems seems to be essential” (Osvath, Fekete, & Voeroes, 2002, p. 3).
Psychological services have been shown not only to be effective with older adults for conditions such as depression (Scogin & McElreath, 1994; Leff et al., 2000) and anxiety (Koder, D. A., 1998; Weatherell, 2002; Pachana, Woodman & Byrne, 2007), but also incontinence (Burgio, 1998) and chronic pain (Cook, 1998). One US study found that every dollar spent on psychological treatment for chronic pain led to a five dollar saving in medical costs (Gonick, Farrow, Meier, Ostmand & Frolick, 1981). Recommendations for the management of pain in residential care facilities are being prepared by the Australian Pain Society and these include non-pharmacologic treatments (www.apsoc.org.au/pdfs/Draft1APSRACPMG.pdf).

Many chronic physical conditions interfere with both current medical treatment and impair the quality of life of those with such conditions. Psychological services can be of substantial benefit in these cases by addressing some of the underlying factors or assist in minimising the psychological impact of such chronic conditions. Stress management techniques for patients with hypertension found that following treatment over 50% of patients were well controlled without any need for medication. The average total medical costs saved per patient over a 5-year period were over US$1,300 (Fahrion, Norris, Green and Schar, 1987).

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

**Current Workforce Situation**

Psychologists in Australia currently have a very limited role in aged care facilities (Snowdon, Ames, Chiu, & Wattis, 1995; Snowdon, Vaughan, & Miller, 1995) or with older people in general (Over, 1991), while their presence in other areas of aged care is limited. Many psychologists who start work in the aged care area sense a lack of specialist skills and do not remain long in positions in rehabilitation or geriatric programs. This is frequently attributed to the lack of proper training (Helmes & Gee, 2003). Currently, the majority of psychologists working in aged care are found in Aged Care Assessment Teams and established memory clinics where individuals with suspected dementia may be properly evaluated. There remains a shortage of well-trained psychologists who can complete the neuropsychological evaluations that are critical for the necessary diagnostic work in the pre-clinical stages of dementia.

There are currently two programs that specifically train psychologists for work with older people, one at the University of Queensland, and the second at
James Cook University. Other universities have been encouraged to start more training for work with older people, and some of these have begun to develop additional courses to help train psychologists. In addition, the APS has an active Psychology and Ageing Interest Group (PAIG), which published a series of documents highlighting the contributions of psychology for older adults. Two documents of the most relevance to this submission are “Guidelines for the provision of psychological services for older adults” (Pachana, Helmes & Koder, 2006), and “Meeting the psychological needs of older adults in Australia” (Koder, Helmes, & Pachana, 2007). The latter, which provides an overview of the roles of psychologist in working with older people, is attached to this submission. PAIG has also been influential in bringing psychologists interested in ageing together, and wakening interest in others, by running biannual conferences and distributing information on-line. There is thus a pool of resources in Australia that can provide the training and support that will orient psychologists to this field and provide them with the skills and confidence to work with older people.

In order to bring the required services and expose more trainee psychologists to the aged care sector, supervising psychologists are needed to deliver the required clinical supervision and training. Such training has been flagged internationally as lagging behind the psychological service needs of this population (De Angelis, 2008). Aged care services often lack the funds to employ suitable psychologists with the required skills and qualifications. This submission will therefore target two groups: trainee psychologists in their sixth year of university psychology training, which typically represent their second and final year of postgraduate Masters-level training prior to registration as a psychologist; as well as suitably skilled psychologists who could supervise these trainees during their fieldwork placement in aged care units. Funding outlined in this submission will also provide administrative support to facilitate effective and seamless management of the program.
The Proposal

It was proposed in the APS pre-budget submission that a scheme that enables the placement of postgraduate psychology students, with appropriate supervision, into RACFs would not only provide much needed services to the residential aged care sector, but also provide a sound training and orientation of trainee psychologists to such a sector, thereby encouraging them to stay and work in the area. A number of such arrangements enacting this model of care with psychology postgraduate students could be rolled out and trialled over three years.

It would be understood that as part of the university course arrangements, students with an interest in working with older adults would be offered a postgraduate placement in a RACF. These students would be fully supervised by qualified, experienced and registered psychologists to carry out assessment and treatment planning of clients. Students would be expected to work within the policies and practices of the RACF and contribute towards the overall multidisciplinary care of clients, such as participating in case conferences and educational in-services with medical, nursing and allied health staff.

It is anticipated that a number of postgraduate specialist psychology programs, including clinical psychology, clinical neuropsychology, and clinical health psychology, would be considered to be the most relevant postgraduate training courses to be targeted. There are over 50 such courses across Australian universities at present.

It is proposed that students would spend around 2 days per week at a specified RACF for one semester (20 weeks). This arrangement would be negotiated by the local university clinical placement coordinator with the RACF concerned. A local professional within the RACF would be identified as the contact person for the student’s placement, and act as the interface between the student and his/her clinical supervisor. The contact person would also facilitate contacts between the student and other professionals within the RACF.

An “Administration” component has been built into the proposal to cover for elements of organisational, process and clerical matters associated with the project. This would be available for both the university and the RACF to cover such resource costs. This has been proposed as 1 hour per week for each individual trainee per institution.

There are a number of possible arrangements for the engagement of clinical supervisors: sessional contracting or employment of a local appropriate clinician; engagement of a local clinician who might combine the supervisory arrangements with a clinic conducted from rooms at the RACF; utilisation of the university clinicians or any combination of the above. RACFs would be approached to participate in the program and the details of the above processes and the most appropriate model of supervision negotiated on a case-by-case basis.
It will be necessary for the participating RACFs to discuss with their staff the various roles and services that postgraduate psychology students can perform, particularly if a range of psychology specialties are available. A period of education and familiarisation is anticipated; moreover, students and supervisors can themselves assist with staff education through in-service opportunities. For this reason, as well as to ensure ongoing good relations between students, the university and RACF staff, an additional hour per week for the supervisors has been allocated. This time would be especially needed during the establishment and set up phase and might be concentrated at these times. However, such additional time would also be vital at various stages throughout the placement to ensure effective implementation and operation.

Services offered by students would fall into one or more of the following categories:

- Collaborate with medical staff on the accurate diagnosis of mental health or neurological conditions;
- Provide evidence-based, non-drug interventions for particular clients or client groups;
- Provide consultations about understanding behavioural changes in dementia, and strategies and techniques for managing disruptive resident behaviour;
- Provide interventions for sufferers from chronic diseases thereby reducing symptoms, improving compliance and lessening distress;
- Provide emotional and practical support for RACF staff; and
- In-service and staff consultative opportunities.

It is anticipated that the introduction of this project could be phased in over 12 months, with Phase 1 being a pilot project utilising readily accessible programs, supervisors and RACFs. There should be a Phase 2 at a later point that allows for an extension of the project to a greater number of universities and RACFs. Conservative estimates by the APS indicate that up to 10 university programs would immediately be able to utilise this proposal and the interest of others for a Phase 2 project could be progressively ascertained. The interest of suitably experienced and qualified supervisors in Phase 2 would take longer to ascertain but could also be co-managed with the universities by the APS. The recruitment of RACFs would need to be managed by the local university placement coordinators. It is anticipated that it would largely be viewed positively by RACFs, particularly as the administrative support for this project are covered. This proposal focuses only on resources needed to complete Phase 1.

**Phase 1: Pilot Project**

To demonstrate the potential benefits, explore the methodology and test evaluation processes, it is proposed that the first phase of the project would be a pilot of the full program. This would identify 10 university post graduate
programs that already have an aged care component to their training and who will already have staff familiar with clinical assessment and interventions relevant to institutional aged care settings. It is anticipated that these 10 programs could easily establish arrangements with 10 local RACFs, contract an appropriate supervisor and appoint a postgraduate student for a semester placement by the commencement of 2013. This placement would involve the student for a minimum of two days a week for 20 weeks. As noted earlier, the two hours per week of clinical supervision will include one hour per week of face-to-face supervision with the student and one hour per week for negotiation and relationship building with the RACF staff. Acknowledgement of resource costs for both university and RACF organisational time is accounted for in the funding of one hour per week per institution of administration allocation.

In addition to the negotiations for a specified role and defined relationships at the RACF, there would be an evaluative component especially for the pilot phase. This would include a set of measures to broadly assess the impact on, and effectiveness of, the program of clinical interventions on both clients and the institutional practice. They would include quantitative and qualitative measures of benefit from both clients and staff (such as a very short Likert scale for staff to complete regarding how effective they feel in managing behaviours) as well as quantitative clinical outcome measures based on before and after tools commonly used in aged care settings (such as the Cohen-Mansfield Agitation Inventory). The APS National Office and the APS Psychology and Ageing Interest Group Working Group, which put together this proposal, would decide on a very brief evaluative battery which would be minimally intrusive in the RACF settings but would give a good measure of efficacy. This would require some centralised project officer and administration time to negotiate details of the evaluation, and then process and report the data.
**Proposed Costs**

**Phase 1: Pilot program (Commencing January 2011)**

<table>
<thead>
<tr>
<th>Activity/Project Component</th>
<th>Cost</th>
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<tbody>
<tr>
<td>Supervisors: (10 university programs contracting 10 supervisors for 40 weeks for 2 hours per week at $200 per hour)</td>
<td>$160,000</td>
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<tr>
<td>Administration: (10 universities and 10 RACFs with 1 hour per week each for 40 weeks at $100 per hour)</td>
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<td>Evaluation: 1 x Project Officer for 12 months at 0.5 EFT ($53,150), plus 1 x Administrative Assistant for 12 months at 0.2 EFT ($14,180)</td>
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<td>Pilot Project Management: 1 x Project Manager (0.1 EFT)</td>
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<td>Infrastructure Costs (15% of project costs)</td>
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<td>Sub total</td>
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<tr>
<td>GST</td>
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<tr>
<td>Total</td>
<td>$332,631</td>
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**Project Deliverables**

Key deliverables of Phase 1 of this project are:

1. 20 postgraduate student clinical placements associated with 10 university programs in 10 local RACFs during 2013 (10 per program for 2 semesters).

2. The collection of evaluation data based on:
   a. Pre- and post- clinical measures of client/resident symptoms and issues (e.g. depression, anxiety, QOL, behavioural issues);
   b. Pre- and post- clinical measures of institutional practices (e.g. GP visits, medication reviews, acute admissions);
   c. Qualitative data from formal surveys of:
      i. RACF staff;
      ii. University placement coordinators and supervisors;
      iii. Students.

3. Interim and final reports will inform future planning and disseminate program outcomes.
Conclusion

In summary, the aims of the Psychology in Aged Care: RACF Placements proposal are as follows:

- Increase the access of residents to evidence-based and cost-effective psychological interventions relevant to their needs;

- Build clinical expertise among postgraduate psychologists in the diagnosis, treatment and management of the aged care community;

- Encourage postgraduate psychology student to undertake clinical training placements in RACFs as part of their university education;

- Increase the capacity for recruitment and retention of specialist psychologists in the aged care sector;

- Improve the capacity of aged care services to deliver training for psychologists through the funding of clinical supervisors; and

- Increase opportunities for aged care services staff to consult with psychologist clinical supervisors regarding the range of health problems experienced by their residents.
References


Davison, T., McCabe, M., Visser, S., Hudgson, C., Buchanan, G., & George, K. (2007). Controlled trial of dementia training with a peer


Appendix 1

About the APS

The Australian Psychological Society (APS) is the peak national body for the profession of psychology, with over 20,000 members, representing over 60% of registered psychologists. The APS operates through its National Office located in Melbourne. Members are supported within the APS by 9 professional Colleges, 27 Interest Groups and 40 Branches throughout Australia. 75% of APS members are female. 73% of APS members work in major suburban areas, 13% in regional centres and the remaining 14% in rural and remote locations.

APS members work in all facets of the Australian community: from early childhood development centres to tertiary education; from criminal justice systems to refugee detention centres; from crisis shelters to large non government organisations (NGO); from independent practice to multinational companies and state of the art health services. During 2009, 27% of APS members were in independent practice, 20% in private sector (including NGO) and government organisations, and a further 18% in the education sector, including tertiary education and schools.

As the representative body for psychologists, the APS has access to a vast pool of psychological expertise from both academic and professional service delivery perspectives. The APS has responsibility for setting professional practice standards, providing ongoing professional development and accrediting university psychology training programs across Australia. It is represented on a number of advisory groups involved in the planning, implementation and ongoing monitoring of Government policy initiatives.

Open communication with its members, plus access to high level psychological expertise and detailed involvement in Government initiatives, enables the APS to significantly influence the psychology workforce to ensure best practice in health service delivery.