Brief on the role of psychologists in residential and home care services for older adults

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Abstract

Objective: This brief examines the evidence that is currently available to inform the provision of psychological services within aged care services, considering both residential care and home care settings.

Method: A narrative literature review of the literature evaluating psychological approaches for common conditions in aged care settings was conducted, focusing on the assessment and treatment of common mental health disorders and dementia. Information on the current employment and training of Australian psychologists in geropsychology was also summarised.

Results: While further research is required, existing literature provides a clear rationale for the benefit of psychological approaches to address a range of conditions, including the management of dementia. There is only limited research focusing specifically on the home care setting, despite the increasing number of older adults who receive aged care services in their own homes. The current provision of psychological services in Australia is critically low, driven in part by funding limitations. Meanwhile, substantial gaps remain in the training provided to provisional psychologists.

Conclusion: A number of key recommendations are made to address the growing need for aged-specific psychological assessments and interventions to be included as part of the delivery of aged care services in this country. Given the continued high prevalence of mental health disorders and dementia within aged care settings, as well as even higher rates of subthreshold conditions, improved access to psychological services for older Australians must become a priority.

Key words: aged care, geropsychology, nursing homes, professional training, psychological services, psychotherapy.
Whilst there has been an increase in clinical opportunities for psychologists working with older adults (Koder, Helmes & Pachana, 2007), the forthcoming need for psychological services for our ageing population is unlikely to be met. Projections from the Australian Bureau of Statistics (ABS, 2013) indicate that the number of older Australians will almost double from 3.2 million in 2012 to 5.8 million in 2031, with particularly high growth rates in those 85 years and older (ABS, 2013). Older adults are expected to comprise one quarter of the population in coming years. Most live at home, with a growing number of aged care services provided to enable frail older people to remain in their own homes as long as possible (‘home care’). However, a sizeable proportion have serious, often multiple disabilities that require a higher level of care and must relocate to a residential aged care facility (‘residential care’). Australian figures suggest that approximately half of all women and one third of men currently aged 65 will enter an aged care facility during their lifetime (Department of Health and Ageing, 2011). These figures will rise as our population continues to age and a greater proportion of Australians will require residential care services.

Unfortunately, working with older adults remains of relatively low interest amongst psychologists, with only 6.1% of Australian psychologists specialising in aged care (Koder & Helmes, 2008a). This reflects the relatively limited teaching and placement opportunities provided during psychologists’ training (Pachana, Emery, Konnert, Woodhead, & Edelstein, 2010) and the small number of psychology positions available for psychologists in the aged care sector compared to services for younger adults or children. Limited opportunities to interact with older clients during training may decrease the likelihood that students would choose to pursue further training and work opportunities with geriatric populations (Hinrichsen & McMeniman, 2002). A survey of Australian registered psychologists published in 2010 suggested that psychologists worked a mean of 1.36 hours per week with
clients aged 65 years and older, compared to 18.57 hours of work with younger adults and 8.1 hours of work with children and adolescent clients (Stokes, Mathews, Grenyer, & Crea, 2010). Although this survey collected data on workplace setting, there were negligible numbers of psychologists who reported working in aged care.

This situation exists despite both clinical and research evidence supporting the many specialist services that psychologists can provide to assist older adults, including those in residential aged care settings. This brief considers the contribution that psychologists could potentially make within the aged care sector, with a particular focus on the management of mental health disorders and dementia. The brief consists of a narrative review of relevant geropsychological literature as well as a description of the current situation in Australia with regards to psychological service provision and specialist training of psychologists. Recommendations are made that would facilitate psychologists playing a more substantial role in the care of older Australians.

Management of Mental Health Disorders

The potential for psychology to make a positive contribution to the mental health of older adults is significant. Many psychologists specialise in the treatment of common mental illnesses such as depression and anxiety, which remain at worryingly high levels within aged care settings. An international review of prevalence studies indicated that one third of older adults in residential aged care exhibited substantial levels of depressive symptoms (Seitz, Purandare, & Conn, 2010), while the most recently available Australian figures suggested that half of all aged care residents have significant depressive symptomatology (Australian Institute of Health and Welfare [AIHW], 2013).
Meanwhile, a recent systematic review of available studies on the prevalence of anxiety concluded that between 14% and 30% of aged care residents have clinically significant levels of anxiety symptomatology (Creighton, Davison, & Kissane, in press).

**Assessment of Mental Health Disorders**

Despite an increase in awareness of depression, research in aged care suggests that half of all clinical cases remain undetected and untreated (Davison et al., 2007). The recognition of anxiety is likely to be similarly problematic, although there is a lack of data regarding the recognition or treatment of anxiety in aged care. However, there have been some positive directions in the assessment of mental health in Australia, most notably the introduction of a depression screen to the Aged Care Funding Instrument that is used to determine the level of funding for resident care. Since 2008, the Cornell Scale for Depression in Dementia (CSDD; Alexopoulos, Young, & Shamoian, 1988) has been administered by nursing staff to older adults admitted to Australian residential aged care facilities. The CSDD is suitable for use with residents both with and without dementia, and this initiative suggests that government bodies recognise the importance of detecting depression in aged care settings.

Unfortunately, a recent evaluation of the use of the CSDD in facilities in the states of Victoria and New South Wales highlighted the lack of clinical follow through for the majority of residents who were identified with depression, so outcomes appear unlikely to have changed (Davison et al., 2012). Another major finding of this study was that staff reported low confidence in using the screening instrument. This is not surprising, given that the assessment of depression in older adults can be complex, with many presenting with significant comorbidities such as sleeplessness, lack of appetite, and fatigue associated with chronic illness, which can act to mask depression. Other common presentations in residential care settings, including cognitive impairment, apathy, and difficulty adjusting to the admission to
aged care, add further complexity to detecting depression and anxiety in older adults. Staff training in the use of validated assessment tools and in how to implement appropriate clinical responses could be provided by psychologists, who are well versed in methods of assessment and tailored interventions. Psychologists could also provide support to staff in the assessment of more complex cases, as well as in assessing anxiety, which currently receives little attention in aged care.

Attention also needs to be directed towards the detection of mental health disorders among older adults who receive aged care services in their own homes, where high depression rates have also been documented (Bruce et al., 2002). The consequences of inadequate assessment of home-based older adults can be profound, with depression and anxiety the largest cause of disability in a Queensland study of burden of disease (Queensland Health, 2013). The authors of a large multicentre study of suicidal behaviour pointed 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).

**Treatment of Mental Health Disorders**

A meta-analysis indicated a poor prognosis for depressed community-based older people, with almost half of those participants still alive two years later continuing to meet criteria for depression (Cole, Bellevance, & Mansour, 1999). This research supports the need for improved responses to depression in this population. Older Australians with mental health disorders have more limited treatment options available than is the case for the younger adult population. Those living in residential aged care facilities have even more truncated options and are almost exclusively treated with psychotropic medications. Australian studies
reviewing treatment provision for depression have indicated that access to psychological treatments is extremely rare in this country, with less than 1% of aged care residents reporting they have received any kind of psychosocial treatment, despite the high prevalence of mental health disorders (Davison et al., 2012; George, Davison, McCabe, Mellor & Moore, 2007). While antidepressants are helpful in many cases, their effectiveness has been challenged, especially for use in people with dementia (Banerjee et al., 2011). The long-term use of psychotropic medications in aged care settings has been questioned (Snowdon, 2010), with particular concerns raised about the use of benzodiazepines with the frail elderly (e.g., increased falls risk). Medical side-effects and interactions are important considerations in aged care settings, where it is common for large numbers of medications to be prescribed to older people with complex medical presentations. Consideration of alternative approaches is clearly warranted.

There is increasing support for the use of psychological interventions with older adults in general, and within aged care contexts specifically. Many older adults have expressed a preference for psychological treatment approaches over medications (Gum et al., 2006). Systematic reviews of randomised controlled trials (RCTs) of psychological treatments for depression and anxiety in community-based older people have reported positive outcomes (Ghaed, Ayers, & Wetherell, 2012; Kiosses, Leon, & Arean, 2011; Krishna et al., 2011; Scogin, Shah, & Floyd, 2013; Thorpe et al., 2009). There are fewer trials in aged care settings and very few studies evaluating interventions for older adults who receive care in their own homes. However, a recent meta-analysis of 17 RCTs in residential aged care settings reported a medium effect size (g = 0.57, 95% CI 0.30 to 0.83) for the use of psychotherapy to reduce symptoms of depression in residents (Cody & Drysdale, 2013). The effective trials applied cognitive behavioural therapy (CBT) and reminiscence therapy, with follow-up assessments
indicating that the reductions in depressive symptoms were maintained for six months after therapy ceased. This highlights one potential advantage of psychological therapies over medical approaches: the longer duration of treatment effects after the end of treatment. The positive impact of CBT in promoting coping skills that have the potential to generalize to future difficulties (e.g., learning strategies to manage stress or pain) is another advantage of this therapeutic modality.

Expert Clinical Guidelines
The growing evidence base indicating that access to psychological services can significantly improve the mental health of aged care residents is reflected in expert clinical guidelines. While there is a lack of Australian clinical guidelines specific to the treatment of late-life mental health disorders in residential aged care facilities, those from the U.S. (American Geriatrics Society and American Association for Geriatric Psychiatry, 2003), and Canada (Buchanan et al., 2006; Conn et al., 2006) have some relevance to the local setting. The U.S. guidelines recommend ‘specialised psychotherapies to be delivered by a trained mental health professional’ and ‘nonpharmacological interventions to be delivered by trained geriatric professionals or trained nursing home staff’ as treatments for major and subthreshold depression. The Canadian guidelines similarly emphasise the use of psychotherapies in reducing the severity of depression. Psychologists are ideally trained to deliver evidence-based psychotherapies such as CBT, and can also provide training and support for nursing home staff in delivering other nonpharmacological interventions, such as the provision of personally meaningful activities, social contact interventions, and reminiscence therapies.

Researchers and clinicians in the US have also developed recommendations for the treatment of depression in older adults living in their own homes (Steinman, Frederick, Prohaska,
Satariano, Dornberg-Lee, Fisher, et al., 2007). CBT was recommended as an evidence-based therapy for depression in this setting. The panel also suggested the use of a team-based model called ‘depression care management’ which includes the screening and evaluation of outcomes by trained practitioners in consultation with mental health experts, in order to enhance engagement with treatments. Psychologists could make an important contribution to such teams.

The direct impact of guidelines from professional organisations in the US on care delivery is difficult to judge. The main driver of change in practice in US nursing homes is the federal government Centres for Medicare and Medicaid Services (CMS), through regulation and through changes in Medicare payment policies (Hartman-Stein & Georgoulakis, 2008; Karlin & Duffy, 2004). However, without the development of guidelines by professional organisations, such as the Society of Clinical Geropsychology, for use in lobbying government groups, change in public policy is unlikely.

**Assessment and Management of Dementia**

Dementia has been described as occurring in ‘epidemic’ proportions with an estimated 266,574 Australians diagnosed with dementia in 2011, and projections to more than double to 553,285 by 2030 (Deloitte Access Economics, 2011). Early diagnosis is essential for people with dementia and their families in terms of future planning and monitoring of the progression of the disease. Australian psychologists remain prominent in their assessment and management roles in dementia diagnosis, with 21% of New South Wales hospitals having a memory disorders clinic attached to their service (Draper et al., 2014). Dementia is a common trigger for relocation of older adults to a residential aged care facility, where 24-hour care can be provided. The most recent Australian data indicated that half of all older adults living in a residential aged care facility now have a diagnosis of dementia (AIHW,
2012), indicating the importance of professionals in aged care settings being appropriately trained in working with people with dementia, and the potential contribution of clinicians with skills in cognitive rehabilitation and dementia care.

**Cognitive Rehabilitation**

Of note over the past few years is the proliferation of cognitive rehabilitation services. Brain plasticity, or “the capacity of the brain to change cortical representations as a function of experience” (Baltes & Singer, 2001, p. 62) has led to a more optimistic attitude in geropsychology, as opposed to regarding old age as purely degenerative. Here, neurones continue to develop across the lifespan as a result of increased mental activity. Cognitive remediation programs (Calero & Navarro, 2007) involve practice, either individually or in a group setting, in a variety of mental stimulation tasks such as speed of information processing or attention. These have been subjected to treatment trials with positive results for both cognitive and psychological functioning (e.g., Martin, Clare, Altgassen, Cameron, & Zehnder, 2011; Naismith, Mowszowski, Diamond, & Lewis, 2013; Rebok et al., 2012), with positive gains persisting for up to 5 years post-intervention (Willis et al., 2006). Computerized cognitive training tasks were the subject of a recent systematic review, also with robust positive findings (Kueider, Parisi, Gross, & Rebok, 2012). Cognitive training techniques have demonstrated success in assisting people with dementia to learn new information as well as improve their memory, and in improving their broader day to day functioning (Creighton, van der Ploeg, & O’Connor, 2013).

The dramatic shift in public consumer attitude to subjective cognitive impairment and its prevention has given rise to a plethora of products including brain training computer games. The interface between advances in technology and improvements in personal cognitive
function (e.g., using personal devices as reminder techniques) is exciting and psychology has much to offer in this area, particularly to enable older adults with cognitive impairment to remain living at home for as long as possible.

**Behavioural and Psychological Symptoms of Dementia**

In many cases, cognitive difficulties give rise to behavioural manifestations of unmet need and/or distress (commonly termed behavioural and psychological symptoms of dementia or BPSD). The negative impact of BPSD on both those with dementia and their carers, be they family or professional home care or residential care staff, has been well documented (Schmidt, Dichtor, Palm & Hasselhorn, 2012). There are costs in the form of physical injury to carers and others, damage to facilities, increased demands upon carer time to deal with such behaviours, and carer distress and burden. Psychologists have been prominent in helping decrease distress and reduce the severity and impact of behaviours such as physical and verbal aggression, absconding, and wandering. Systematic reviews have demonstrated that psychological approaches are effective in treating both behavioural and psychological symptoms, when tailored to the needs of individual older adults (O’Connor, Ames, Gardner, & King, 2009a, 2009b).

Australian efforts in the management of BPSD in residential aged care settings have built a strong case for use of individually tailored nonpharmacological interventions that address the underlying causes of particular symptoms (e.g., Bird, Llewellyn-Jones, Koreten, & Smithers, 2007; Davison, Hudgson, McCabe, George, & Buchanan, 2007). This psychological approach has demonstrated positive outcomes, lowering both the severity of BPSD and levels of staff stress, as well as reducing numbers of medical consultations by visiting general practitioners, with cost estimates showing savings in this approach over standard medical
care (Bird, Llewellyn-Jones, Smithers, & Korten, 2002). Another innovative approach trialled in Australia is humour therapy, which was demonstrated in the SMILE study (Sydney Multisite Intervention of LaughterBosses and ElderClowns) to significantly reduce levels of agitation in nursing home residents (Low et al., 2013).

These approaches concur with international and Australian guidelines for the management of BPSD (e.g., National Prescribing Service [NPS], 2011; International Psychogeriatric Association, 2002), which unanimously recommend the use of nonpharmacological interventions as the first line approach for managing behavioural symptoms of dementia. Unfortunately, current practices in Australian aged care facilities are not consistent with expert guidelines: treatment is predominantly pharmacological, with high rates of antipsychotic use and only limited ongoing revision of medications (O’Connor, Giffith & McSweeney, 2010). This is despite high awareness of the side effects and risks of pharmacotherapy with this population (NPS, 2011).

A lack of available clinical expertise in implementing psychological treatment approaches may underlie this discrepancy. Concerns have been raised that residential aged care staff do not receive adequate training in managing BPSD (Alzheimer’s Australia, 2013), with behavioural disturbance the primary reason for which facilities request specialist input (Draper, Meares, & McIntosh, 1998). While specialist services such as the Dementia Behaviour Management Advisory Service (DBMAS) and aged mental health services play a vital role in the treatment of residents with BPSD, there are insufficient resources in this country to meet the current high incidence of these symptoms, and the situation is likely to worsen as the population further ages. The trend towards older people receiving aged care services in their own homes for as long as possible also presents challenges for the
management of BPSD. Appropriately trained psychologists could play a key role in
developing and implementing treatment plans for older adults with BPSD, as well as
providing evidence-based training and ongoing support for home care and residential care
staff. There are a number of freely available resources available to assist clinicians in this
work, such as the BPSD Guide (Burns, Jayasinha, Tsang, & Brodaty, 2012) which has
accompanying electronic resources and training packages. This is an example of the
substantial contribution made by psychologists and colleagues in developing resources and
disseminating information that can have a positive impact in aged care. Management of

Other Clinical Conditions Related to Ageing

While there has been a focus on depression, anxiety, and dementia, the use of psychological
therapy in other clinical conditions commonly experienced in later life has also received
increased attention, both in the research and clinical fields. This work is of direct relevance to
both residential and home-based aged care settings, where older adults present with a range
of medical conditions, functional disability, and pain. The effectiveness of CBT in helping
people with chronic pain has been supported by a large body of research and confirmed in a
recent Cochrane review (Williams, Eccleston, & Morley, 2012), and psychologists now have
an increased profile on pain management teams. The recognition of the role of psychological
approaches to the management of medical conditions, such as pulmonary disease (Livermore,
Sharpe, & McKenzie, 2010) and heart disease (Hambridge, Turner & Baker, 2009) is also
promising. Many chronic physical conditions have important psychological consequences
that can interfere with medical treatment and impair the quality of life of those with such
conditions. Psychological services can be of substantial benefit in these cases, as well as in
assisting older adults to cope with other conditions that are common in later life, such as
sleep disorders, with support for CBT as an evidence-based treatment for insomnia (Dillon,
Wetzler & Lichstein, 2012).
Other important roles include helping older adults to adjust to life in a residential aged care facility or to adjust to changes in functional capacity or to sensory impairment, assisting in recovery from injury, and providing grief counselling. Psychologists can also provide support for family and staff care-givers in coping with their demanding roles, with evidence for psychoeducation and psychotherapy in treating distress in family caregivers (Coon, Keaveny, Valverde, Dadvar, & Gallagher-Thompson, 2012). These are all prominent clinical issues in both residential and home care settings. Psychological interventions can provide lasting benefits and can help older people maintain their independence to the greatest extent, which may delay the decision to place an older adult in an institution (Mittelman, Ferris, Shulman, Steinberg, & Levin, 1996).

The Current Australian Context of Psychological Service Provision in Residential and Home Care Settings

While the case for improving the provision of psychological services for older adults is compelling, Australia continues to lag behind other countries such as the United States (Molinari, 2003) in funding psychological services to meet the needs of this growing population. Psychologists are prominent in the growing number of hospital-attached memory disorders clinics as well as in cognitive rehabilitation services, where their assessment and management skills are well recognised. However, in the residential aged care sector there is only limited access to psychological services through the government-funded agencies that service residential facilities, such as the DBMAS and aged persons’ mental health services. These services have limited resources, and may not always have a psychologist on staff. For example, the whole state of South Australia is currently serviced by only four mental health teams, one of which does not employ a psychologist.
Despite limited access to government mental health services, most aged care residents receive no support to access psychological services from private psychologists. This is in contrast to the rest of the Australian population, who can receive rebates for psychological services through the Better Access to Mental Health scheme that was introduced in 2006 by the Commonwealth Government. Ten sessions of therapy per year is permitted with rebates via the Medicare system for clients referred by general practitioners and psychiatrists.

Unfortunately, older Australians in Commonwealth funded residential aged care places (the vast majority of residents) are ineligible for Medicare rebates under this scheme, making the costs of private therapy out of reach for a large proportion of older adults.

While it might be argued that aged care facilities could fund private psychology sessions directly, there is no history of psychological service provision in aged care in this country: facility managers may not be aware of the evidence for this treatment approach or how to access a psychologist. There are also limitations to the funds available for such services, with service providers typically catering to a number of different needs for each resident. Very few aged care facilities employ a psychologist directly, as illustrated by a recent survey of 400 facilities in Australia (Stargatt, 2015). Of the 81 facilities that responded to items regarding the employment of psychologists, only 14% (n = 11) indicated that a psychologist was employed, in either a casual (n = 4), part-time (n = 6) or full time basis (n = 1). It is important to note that this survey was conducted by a group of Australian geropsychologists and distributed to aged care facilities through their networks, and may in fact be an overestimation of the rate of employment of psychologists in the broader aged care sector.

In the absence of policy changes, and given the continued funding limitations of aged care providers, it is unlikely that this situation will change and there is an expectation that the
current over-reliance on medications to treat mental health issues in older adults will continue. Alternative models to funding psychologists to provide direct services to aged care recipients may be developed: for example, employing psychologists within onsite learning and development teams to help facility staff learn how to proactively manage BPSD and other presentations, and to establish protocols for early intervention with residents whose depressive symptoms are picked up with routine screening or who are at risk of developing a depressive disorder (e.g., with an acute illness, poor social support, or difficulty adjusting to institutionalisation). It is important to recognise that aged care nurses often provide informal psychological support within their carer roles, and many facilities offer counselling through pastoral care services. These staff may benefit from regular access to a psychologist to support their work, for example in identifying evidence-based strategies and avenues to refer more complex cases. Further consultation between psychologists and the aged care sector is required to design and evaluate models that may improve the wellbeing of older adults even within the current funding constraints.

The situation is better for older adults who receive aged care services at home, who are eligible for the Better Access to Mental Health Scheme, although it is important to note that dementia is not an eligible condition for rebated services, limiting the support available for the growing number of Australians with dementia who continue to live in their own home. There are also opportunities for home-based older adults to access psychological services in the primary health care sector in the form of the Access to Allied Psychological Services scheme and the Enhanced Primary Care program, with government rebates provided. Older war veterans have access to psychologists (as well as other allied health providers) through the Department of Veterans Affairs, which continues to support psychologists working with home- and residential-based veterans.
Current Training Opportunities in Geropsychology

A survey conducted in 2007 reported that only two Australian postgraduate clinical psychology programs out of the 36 available offered a formal concentration in geropsychology (Pachana et al., 2010), which is noticeably low. This study also noted that only a small proportion of faculty staff had a clinical or research interest in geropsychology or had received specialised training in this field. Specialist training in working with older adults remains at low levels, despite the widespread awareness of the ageing of the population, and attention to addressing the deficit in geropsychological training is required. However, student interest in specialist programs appears to be low. Since the time of the Pachana et al. (2010) survey, one of the postgraduate programs in geropsychology has ceased, due to insufficient student enrolments. Koder & Helmes (2008b) reported that only 4.8% of their Australian post graduate student sample indicated that they intended to specialize in aged care. Therefore attitudes of future practitioners need to be addressed to promote working with older adults.

Facilitating good clinical exposure through placements has been cited as the main influence on interest in working with older adults, with direct training being the optimal focus in shifting attitudes, as opposed to increasing ageing course content (Koder & Helmes, 2008b). This also supports findings with practicing psychologists that positive clinical exposure is the strongest influence on whether a psychologist works with this population (Koder & Helmes, 2008c).

A recent initiative offers guidance for universities in how to provide experience in working with older adults. Swinburne University of Technology in Melbourne has offered clinical
placements within nursing home and community settings since 2011, in order to provide older adults with access to counselling services and train psychologists in working with this population. This service has been positively evaluated by both service recipients and the psychology students (Bhar & Silver, 2014), and provides a cost-effective model for the provision of mental health services in the aged care sector as well as for the training of the future workforce.

While innovations such as this program offer promise, there is a serious risk that the future needs of older Australians will not be met due to a substantial lack of psychologists trained and experienced in providing a broad range of psychological services to this population. Other developed countries such as the United States and the United Kingdom have raised similar workforce fears and responded through the development of guidelines and competencies for training and practice within the field of aged care (e.g., American Psychological Association, 2014; Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009; Molinari, 2011; British Psychological Society, 2006). Australian guidelines were published in 2006 (Pachana, Helmes & Koder), which represent an important resource for psychologists in this country, but further efforts are required to ensure Australia has an adequate number of trained psychologists to meet the projected increase in our aged population.

The availability of multidisciplinary courses, such as the online Bachelor of Dementia Care offered by the University of Tasmania, the Graduate Certificate in Dementia Care at the University of Wollongong, the Master of Applied Gerontology at Flinders University, and the Master of Ageing offered at Melbourne University provide an opportunity for interested professionals, including psychologists, to develop skills in the care of older adults. These courses reflect a growing awareness of the importance of providing appropriate training of
aged care professionals, but in general, psychologists make up only a small proportion of enrolments in these generic courses. While they include content on aged mental health, these courses do not provide specific training that enables psychologists to develop a high level of competence in applying psychological assessments and interventions to older adults. Although these courses are a very welcome addition to the training opportunities, a preferable model would be to include these skills as core components of the clinical training in all postgraduate psychology programs. In the meantime, the Australian Psychology Society (APS) online Practice Certificate in Services for Older Adults has been developed to provide education in ageing and bolster the knowledge of psychologists with an interest in providing services for older adults.

Conclusion

More funded psychology positions are urgently required if there is to be a significant and sustained impact on the health and wellbeing of the growing number of older Australians in the residential aged care and home care sectors. There is established evidence for the efficacy of psychological interventions in addressing the myriad of clinical issues found in aged care settings, including very high prevalence disorders such as depression, anxiety and dementia, where psychologists can play a key role. There are a number of challenges to overcome, however, if there is to be an improvement in the range of treatments provided to older Australians in order to better meet their needs; including appropriate training of psychologists in this country, increased promotion of evidence-based nonpharmacological approaches to key stakeholders in the aged care sector, a greater focus on the home care setting, and addressing current funding inequities for older Australians living in aged care facilities.

Recommendations

Provision of psychological services:

1. Psychologists with relevant experience and training to be funded under Medicare for services provided to all residents of aged care facilities with mental health disorders.
2. More positions for psychologists to be funded for Aged Care Assessment Teams in order to improve accuracy of assessments and better meet the needs of older adults.

3. The Department of Health and Aging to establish a review to determine the needs for psychological services to be provided under the home care programs. The substantial number of cases of emotional and behavioural problems among older people in the community warrants an increase in the provision of effective, non-pharmacological services.

Consultation and communication with aged care:

4. Increased consultation between the psychology profession in Australia and the aged care sector, to determine innovative models to allow psychologists’ expertise to make a greater contribution to the wellbeing of older adults.

5. Aged care organisations to be provided with information about evidence-based psychological treatment options, including how to access services.

Research:

6. Psychological research evaluating interventions to improve the mental health and wellbeing of older adults living at home and in residential aged care facilities, particularly those with dementia, as a funding priority. The absence of research into treatments for those who receive aged care services in their own homes is a particular concern given the rapid increase in this population.

Clinical guidelines:

7. Development of clinical guidelines for the assessment and treatment of mental health conditions in residential and home care settings specific to the Australian context.
Training:

8. Training in geropsychology needs to be systemically integrated into professional postgraduate psychology programs and beyond to provide emerging and experienced psychologists with competencies for working with older people.

What is already known about this topic:

- Depression and dementia are common in aged care.
- Psychological treatments have demonstrated efficacy in a range of conditions in later life.
- Expert clinical guidelines recommend nonpharmacological interventions for late-life depression and behavioural symptoms of dementia.

What this topic adds:

- Australian aged care residents have very limited access to psychological assessment or treatment, instead receiving predominantly pharmacological approaches. This is in contrast to the range of services available to the general population.
- Psychologists could provide training and support to aged care staff, as well as direct provision of psychological services to older adults.
- Interest in specialist geropsychological training remains at low levels, with limited placement opportunities providing a further barrier to the future provision of psychological services within the aged care sector.
References


patients. *American Journal of Psychiatry, 159*, 1367-1374. DOI:
10.1176/appi.ajp.159.8.1367


standards. *International Psychogeriatrics*, 21, 241-251. DOI: 10.1017/S1041610208008223

O’Connor, D. W., Griffith, J., & McSweeney, K. (2010). Changes to psychotropic medications in the six months after admission to nursing homes in Melbourne, Australia. *International Psychogeriatrics*, 22, 1149-1153. DOI: 10.1017/S1041610210000165


